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BALCONY

The Nebraska Medical Journal

THE NEW YORK ACADEMY
OF MEDICINE
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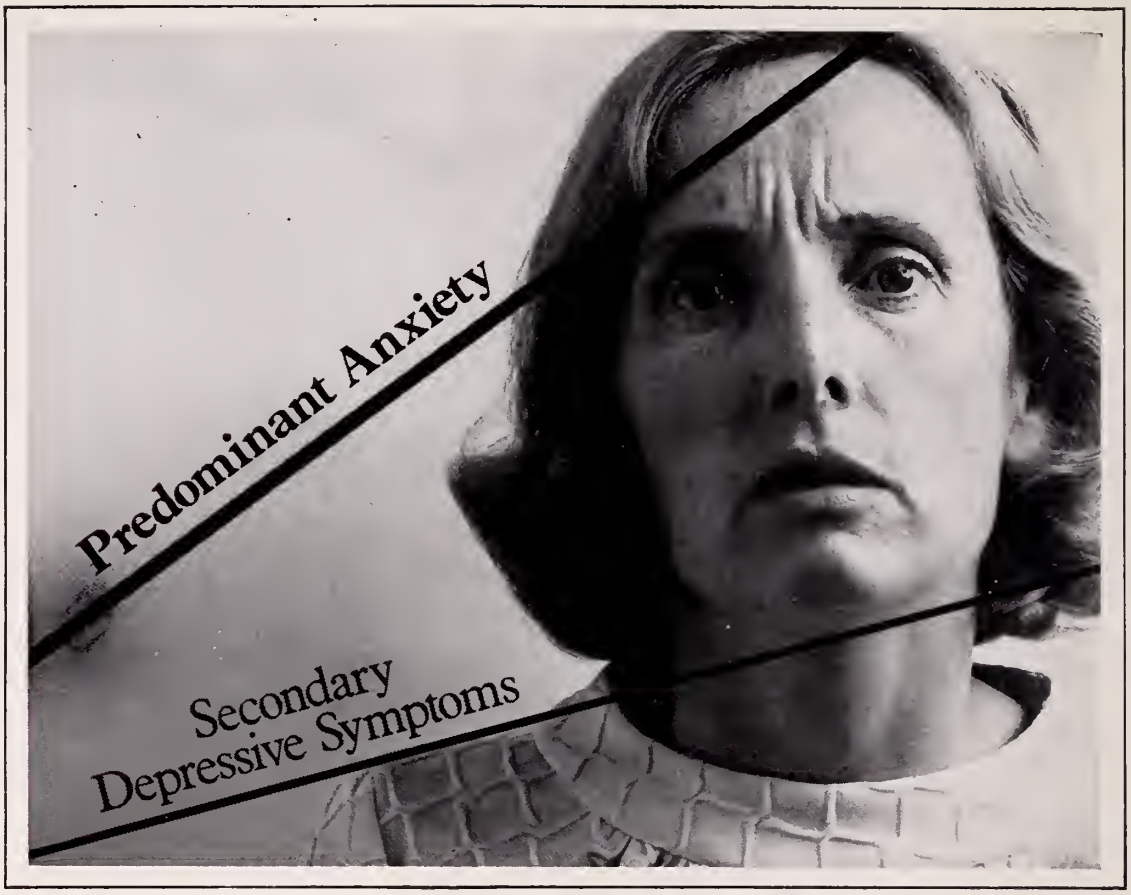
Tell me how many thoughts there be
In the atmosphere
Of a new-fal'n year,
Whose white and sable hours appear
The latest flakes of Eternity:
Beddoes

January, 1974



This psychoneurotic often responds

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

447144

When you determine that the depressive symptoms are associated with or secondary to predominant anxiety in the psychoneurotic patient, consider Valium (diazepam) in addition to reassurance and counseling, for the psychotherapeutic support it provides. As anxiety is relieved, the depressive symptoms referable to it are also often relieved or reduced.

The beneficial effect of Valium is usually pronounced and rapid. Improvement generally becomes evident within a few days, although some patients may require a longer period. Moreover, Valium (diazepam) is generally well tolerated. Side effects most commonly reported are drowsiness, ataxia and fatigue. Caution your patients against engaging in hazardous occupations or driving.

Frequently, the patient's symptoms are greatly intensified at bedtime. In such situations, Valium offers an additional advantage: adding an *h.s.* dose to the *b.i.d.* or *t.i.d.* schedule can relieve the anxiety and thus may encourage a more restful night's sleep.

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symptom complex to Valium® (diazepam)

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The Nebraska Medical Journal

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JANUARY 1974 VOL. 59, NO. 1

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The patient with asthma or allergy: another type for Tylenol® (acetaminophen)

When the allergic patient has a condition requiring an analgesic, a new problem arises. "Idiosyncrasy to salicylates is not rare and is usually manifested by skin rashes and anaphylactoid reaction. Sensitivity to these drugs occurs more frequently in patients with asthma and allergy."[1] Moreover, the previous ingestion of aspirin without ill effects is no guarantee that subsequent use will not precipitate a severe reaction.[2]

TYLENOL (acetaminophen), on the other hand, presents little risk of allergic reaction, even in patients sensitive to aspirin,[3] making it the preferred analgesic for the allergic patient.

This is only one of several 'types for TYLENOL'—that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Modell, W., ed.: Drugs of Choice 1970-1971, St. Louis, The C. V. Mosby Company, 1970, p. 196. **2.** Goodman, L. S., and Gilman, A., ed.: The Pharmacologic Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 327. **3.** Maslansky, L., Paper delivered at Fourth International Congress of Allergology, New York, Oct. 18, 1961; abstracted Excerpta Med. Internat. Congress Series, No. 42, p. 124.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

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Illustrations should be numbered and their locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be in black (India ink) on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

Manuscripts (original, not a carbon) should be sent directly to the Editor at the Journal's address.

Letters to the Editor submitted for publication should be prepared as above, and must carry the notation: To be Published.

Reprints should be ordered from the printer, Norfolk Printing Co., Inc., P.O. Box 278, Norfolk, Nebr. 68701.

Our Medical Schools . . .

Heart-block study

Creighton University's Departments of Preventive Medicine and Cardiology have received a $35,000 grant from the National Heart and Lung Institute. The money will be used to study a hereditary form of heart block discovered by members of these departments.

The study was initiated when it was discovered that a heart-block patient had relatives who were similarly affected. Initial studies undertaken by Drs. Henry T. Lynch and Syed Mohiuddin resulted in the discovery of a new medical syndrome now referred to in the medical literature as "Hereditary Progressive Atrioventricular Conduction Defect."

The Creighton physicians said the family studies will involve over 1,000 blood relatives who are available for detailed evaluation. This represents only a few branches of the family. Preliminary information indicates the disease is present in other branches of the family also.

Creighton builds

Construction is now underway at Creighton University on Unit III of the Doctor C. C. and Mabel L. Criss Medical Center — the newest phase of the University's development of a complete health professions education and care center. The new building, costing approximately $6.5 million is scheduled for completion in August, 1975. The facility will provide 117,000 square feet of instructional space on six floors. It will provide a permanent home for Creighton's School of Pharmacy as well as faculty office space and classrooms for the School of Medicine.

Family Practice at Creighton

Dr. Joseph Holthaus, Dean of Creighton University's School of Medicine, has announced that the Division of Family Practice has been elevated to departmental status and Dr. Michael Haller has been appointed Chairman of the new department.

Immunocompetence Following Allogenic Bone Marrow Transplantation in Man — R. H. Halterman et al (National Cancer Institute, Bethesda 20014). Transplantation 14:689-697 (Dec) 1972.

Immune competence of four patients with acute lymphocytic leukemia who were engrafted with bone marrow from their HL-A-matched mixed leukocyte culture-compatible siblings was assayed during the pre- and posttransplant periods. Two patients who did not develop graft-vs-host reaction (GVHR) demonstrated depression of their lymphocyte response to phytohemagglutinin in vitro. In these patients, an intact efferent arm of delayed hypersensitivity reaction was demonstrated posttransplant by positive skin test reactions to multiple antigens. Humoral immune capacity was documented in both patients. The third patient, with moderately severe GVHR, had intact humoral immune function but was anergic to 1-chloro-2,4-dinitrobenzene and skin test antigens. This patient also developed and survived a viral infection. The fourth patient, who died of GVHR with concurrent infection, failed to demonstrate humoral or cellular immune reactivity.

FUDR As Adjuvant to Surgery in Cancer of Large Bowel — R. W. Dwight et al (VA Hosp, Boston 02109). J Surg Oncol 5:243-250 (No. 3) 1973.

In a controlled trial 735 patients with carcinoma of the large bowel were studied in an effort to determine the possible benefits of using FUDR as an adjuvant to surgical resection. Patients randomized to treatment received a reduced course of the drug on the first, second, and third postoperative days, and a second standard therapeutic course approximately six weeks later. There was no significant difference in postoperative complications or 30-day mortality. The second course of chemotherapy was an apparent contributory factor in the death of six patients. Long-term follow-up studies showed no difference in survival between patients receiving the drug and those treated by surgery alone.

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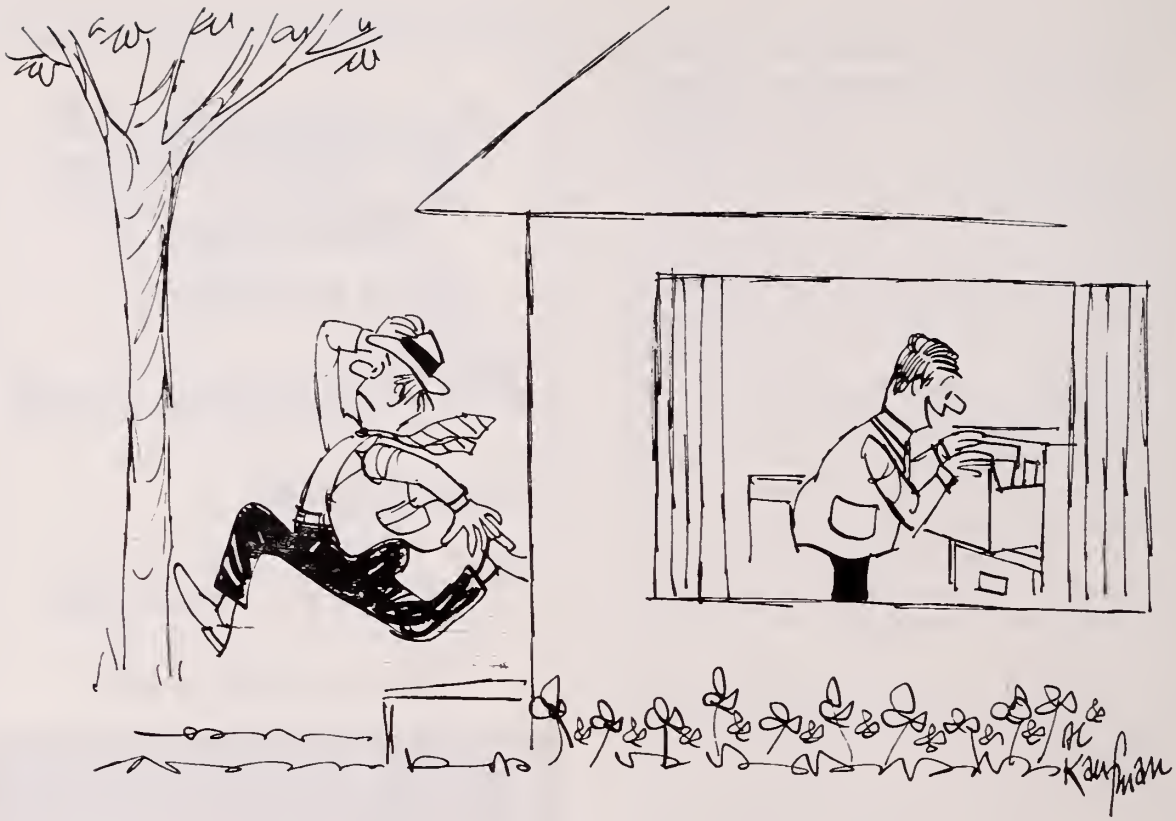

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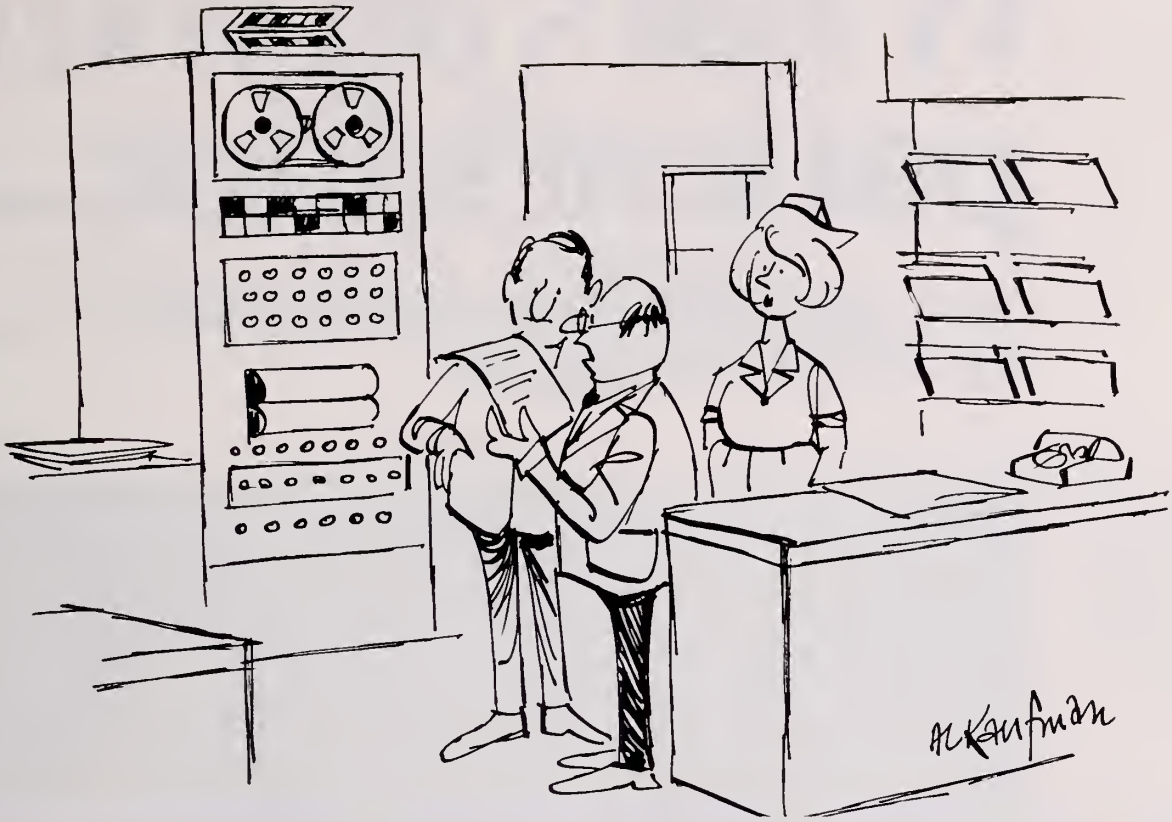

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What's on your patient's face...

may be more important than his chief complaint

Patient P.T.* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.

Patient P.T.* seen on 6/12/67, seven weeks after discontinuation of 5% FU cream. Reaction has subsided. Residual scarring not seen except that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J

The lesions on his face are solar/actinic— so-called "senile" keratoses... and they may be premalignant.

Solar, actinic or senile keratoses

These lesions may be called by several names, but they usually can be identified by the following characteristics. The typical lesion is flat or slightly elevated, of a brownish or reddish color, papular, dry, rough, adherent and sharply defined. They commonly occur as multiple lesions, chiefly on the exposed portions of the skin.

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Treatment with Efudex provides highly favorable cosmetic results. Incidence of scarring is low. This is particularly important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

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New hospital on Creighton campus

Dr. Joseph Holthaus, Dean of Creighton University's School of Medicine, was the keynote speaker at the school's recent Alumni Dinner. The 300 persons in attendance heard Dr. Holthaus outline plans for a new $61-million teaching hospital which will be built on the Creighton Campus by the Creighton Omaha Regional Health Care Corporation.

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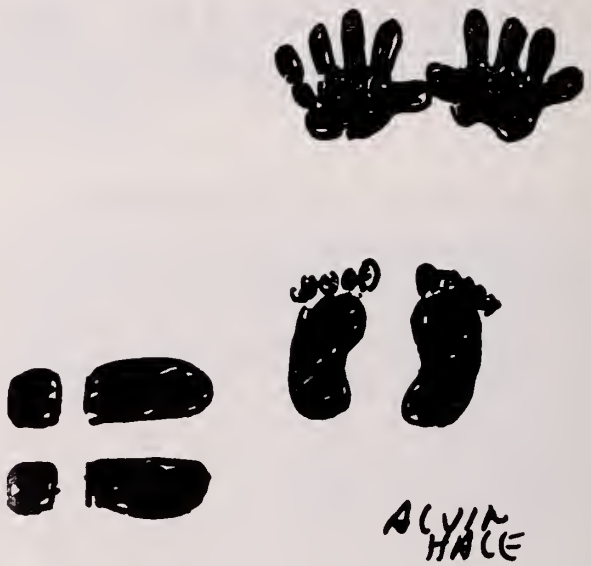

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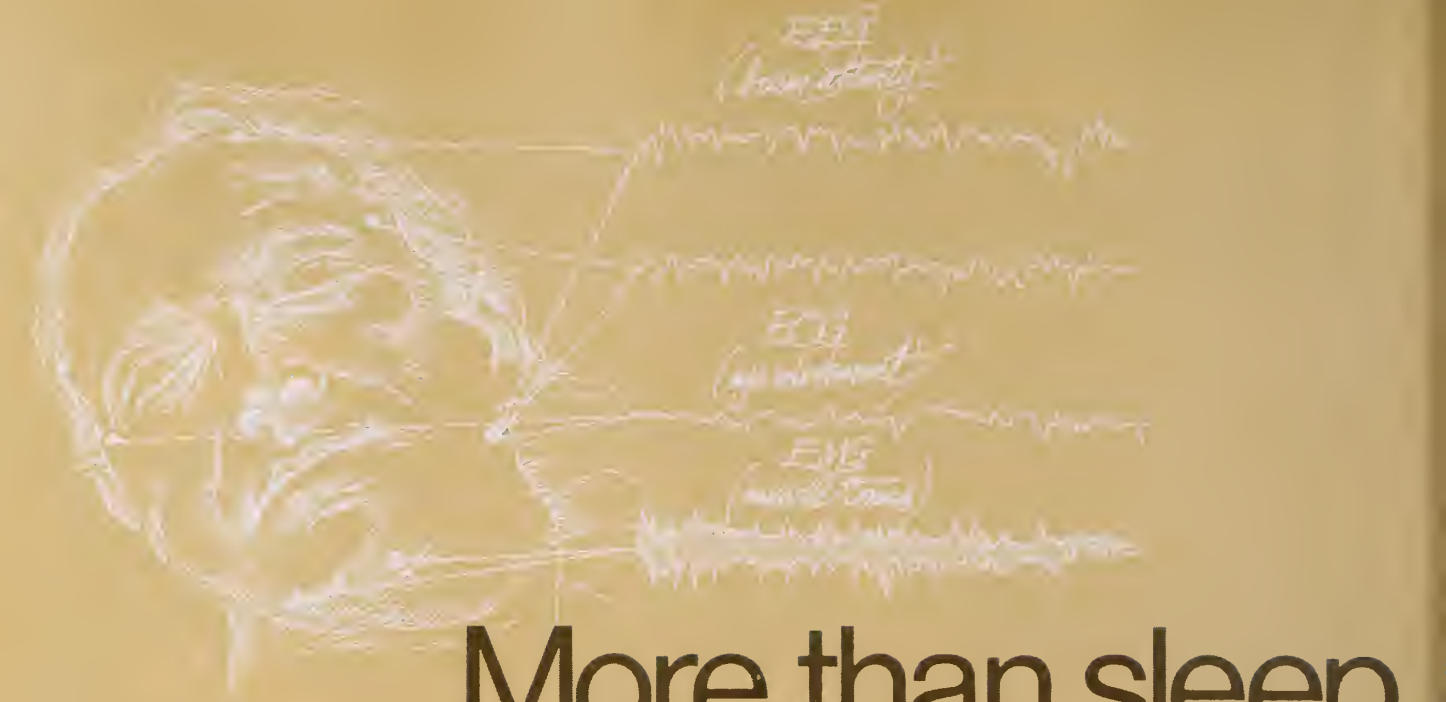

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Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e g*, excitement, stimulation and hyperactivity, have also been reported in rare instances

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The Weight of Professional Opinion

It's time for action to defend the laws and regulations that protect your patients against drug substitution.

These professional and trade organizations are united in supporting antisubstitution statutes and regulations:

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The Executive Committee of the National Association of Retail Druggists

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The National Wholesale Druggists' Association

oint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is o affirm the support of the participat- ng organizations for the laws, regula- ons and professional traditions which rohibit the unauthorized substitution f drug products.

Traditionally, physicians, den- sts and pharmacists have worked ooperatively to serve the best inter- sts of patients. Productive coopera- on has been achieved through nutual respect as well as a common oncern for the ideals of public ervice. This mutual respect has been eflected, in part, by joint support ver the years for the adoption and nforcement of laws and regulations pecifically prohibiting unauthorized ubstitution and encouraging joint iscussion and selection of the ource of supply of drug products. he basic principles of medical, den- al and pharmacy practice are thus tilized and preserved in the interest f patient welfare.

The antisubstitution laws have ot obstructed enhancement of the rofessional status of pharmacy any nore than they have in and of them- elves guaranteed absolute protec- on from unsafe drugs, or freed hysicians, dentists and pharmacists rom their responsibilities to patients. s a practical matter, however, such ws and regulations encourage inter- rofessional communications regard- ng drug product selection and assure ach profession the opportunity to xercise fully its expertise in drug sage, to the advantage of patients.

Physicians and dentists should e urged to increase the frequency nd regularity of their contacts with harmacists in selection of quality rug products, recognizing that economies to patients can be im- proved through such communica- tion, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physi- cians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selec- tion remain primary and do not per- mit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved under- standing and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthor- ized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

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THE NEBRASKA MEDICAL JOURNAL

THE ROMANCE OF ANATOMY

The names of the parts of the body are rich in history. Some structures are glorified by this, while a few organs are unfortunately downgraded. This may have had its origin in the old practice of divining by plucking at entrails. Consider the head. He has a good head on his shoulders, we say. Or again, the president is the head of the state, or we speak of the fountainhead of knowledge, and of maidenhood, too.

You're all heart, we tell someone who is generous. When we long for somebody, we have heartache. But when the stomach is at fault, we call it heartburn. The stomach is blamed for many other things, though, and when you have a pain anywhere in the abdomen, you complain of stomachache, after which you may have your appendix removed.

Anyone we do not like is a pain in the neck, of course. A person of a certain temperament is called a man of his kidney, which is strange.

I think somebody has written my bowels yearn for thee.

He has a strong back, we say, but we speak of having no backbone, too; and O my aching back, and get off my back.

He's a lily-liver means he is a coward and probably has a white liver. Yellow skin means coward, too, not jaundice.

And when you simply explode, you vent your spleen. If you are awkward, you're all thumbs. There are others, as heart and hand, and shoulder to the wheel and nose to the grindstone; and eyes are the windows of the soul. The soul used to be in the abdomen; now it may be in the head. There's hip and thigh, and you gird up your loins; and if you are inquisitive, why then, you are nosey.

If you work hard, you use elbow-grease; what is near is at your elbow; and if you are poorly dressed, you are out at the elbows. To bend the elbow is to drink, and if you are cramped for space, you want elbow room. If you are hippish, you are melancholy, believe it or not. Up to the ears means you've had it, but all ears signifies undivided attention.

Keep a stiff upper lip.

—F.C.

BIG WORDS AND LITTLE SENSE

The medical student learns his lingo early, so that words like cholecystectomy and pseudoarthrosis are understandable and come tripplingly from his tongue. He is taught to comprehend little pieces of words and to put them together, and to take them apart when others have assembled them. In addition, we have abandoned Anglo-Saxon etymology and have clung to Latin and Greek. This makes it easy for foreigners to read us, but difficult for patients to know what we are saying.

I have no quarrel with the phrase subtotal gastrectomy; there is no other way to say it. But when we get to pancreaticoduodenostomy and spondylolisthesis, we have gone too far; we have paid too much for our jargon. The longest English word is probably a medical term, and this is a claim of questionable value; I think it is pneumonoultramicroscopicsilicovolcanoconiosis. Since what we write is English, it is surely better to leave Latin and Greek and to invent new little words that will mean what our long jawbreakers do. In some cases, technicality and circumlocution have replaced common sense and even sanity; witness laminectomy. This word means no more than laparotomy; it suggests that an operation was performed on the back, but it does not say what was done.

Since we talk to and write for an English-speaking audience, I suggest that we have gone too far, and that while there is yet time, we scrap our outmoded system and replace it with another. Choledochocholedochorrhaphy is a word that should have died aborning. Whatever it means, it is too long, and even sesquipedalian will not describe it.

Let us write a completely new dictionary of medical words. Let us restrict the length of each to only a few letters, and let us further require that every word seems to say what it means.

—F.C.

ARE DEFECTS GOOD FOR YOU?

Few of us are normal, and being normal may be the most abnormal variation of all. But those with defects have in some ways turned out better than the average.

I once heard Joslyn speak, and he said if you want to live long, get diabetes, because the life span of a diabetic who takes care of himself is longer than that of the nondiabetic, and his point was that diabetics take care of themselves.

I have read that the armed forces were actually looking for colorblind people. I think they felt that these individuals, while flying in an airplane, would not be deceived by camouflage.

A famous composer is supposed to have died of a brain tumor, and I wonder if the beginnings of the disease did not somehow cause him to become a musical genius. And another became deaf, and wrote beautiful music.

In a recent study, it was shown that one-eyed automobile drivers were safer drivers than those with two eyes. The monocular drivers had only one fourth as many accidents as the two-eyed individuals.

It is possible, since you slow down after a heart attack, that your life span is lengthened; so that if you finally die of something else, you will have lived longer because of your heart disease.

Count your many blessings, that wonderful old hymn went.

Blessings may have their origins in compensation, as in the case of the polio victim who exercises and goes on to become a champion long-distance runner.

Some things may be blessings in disguise.

—F.C.

REFERRING TO YOURSELF

References fill me with mixed emotions. They are scholarly, pedantic, and useful. My Annotated Alice is my prize; I have three or four other versions of A in W, and one is in Latin, which anyone who likes browsing of this sort may borrow.

They are often used to impress the reader. But if 300 other workers preceded you in this field, it robs you of any claim to originality. I think 15 references are enough. References should be referred to. Bibliographies are meant to be prestigious and impressive, but they are only offensive, and should be outlawed.

But the prize is referring to yourself. An occasional self-alluded-to footnote is sometimes understandable, although the urge can be resisted. But a list of six or eight self-aggrandizing annotations is an obvious misdeed.

One of the prime offenders is the question answerer in medical journals. He has already been identified as an authority, but too often he feels the need to say so himself, and supplies only one reference, and guess who.

If authors were charged a fee for each reference, it might shorten the list, or we would get articles from only wealthy writers. But we might impose a whopping penalty for every self-referral. Or we could simply make it illegal.

—F.C.

ON NONDIAGNOSES

You do not pay a doctor to say he does not know, any more than you pay an umpire to say he did not see the play. But if you do not know, it is remotely possible that you may make the patient feel better if you change his English to your Latin; it is of course still better if you do not endanger his life as you go on.

But this is not playing the good doctor. If he says he has a pain in the joint, and you tell him he has arthralgia, it is hardly worth your diploma. If the laboratory reports a uric acid level of 15, a diagnosis of

hyperuricemia, or worse still, uricemia, is at best a free translation of not knowing, not caring, and not having time to find out.

If the hemoglobin is only 10, you dismiss it with a diagnosis of anemia of unknown etiology, and idiopathic is even better if you go in for this sort of nonsense. In the old days, we gave placebos when we had nothing specific. Today, our diagnoses have too often become placebos, treated by specific drugs that are not always specific, like antibiotics and vitamins.

Cephalgia is headache, and nothing more; pyrosis is heartburn; hematemesis means vomiting blood; and obesity means he's fat, but patients have found that out. But idiopathic uricemia or arthralgia are poor sorts of diagnoses, and I submit that all this nondiagnosing and getting to the next case does not advance the cause of medicine.

But maybe I have subacute, nonspecific, idiopathic, atypical malaise.

Of unknown etiology.

—F.C.

I DO, I DO

I do not know why there are repetitious words, but there are. I eat a bonbon and watch the cancan and make a booboo, and I should like to live in Walla Walla.

In our own field, we have beriberi and mali-mali and divi-divi, itai-itai, and even glou-glou. And there are the murmur, the tsetse, and the testes. I think itai means ouch, or it hurts, and it is a disease. So is beriberi, and that means I cannot, or I can't do it. Glou-glou is a gurgle, of course, and furfur means dandruff.

There is the pompom girl; and in war, ack-ack and dumdum bullets. There's more: chi-chi and froufrou and tomtom and pawpaw and tartar. And I've heard of the chacha, which may mean yes yes, and may even be the chachacha; and the go-go girls.

The world's record is held by the little engine that could. It said, I think I can, I think I can.

—F.C.

ON SIGNING YOUR NAME

Practiced signatures have become a status symbol for those who need status symbols. Swagger sticks were once done away with by a general who suggested that they be discontinued, but added that those who felt the need for them could carry them. I have seen signatures that were obviously practiced, and that were completely unreadable. The message was plain; you were impressed by the fact that the writer was so busy that he had time only for an undecipherable scrawl.

These are the people who ask a secretary to get you on the telephone, while they sit by, doing nothing, but impressing the daylights out of you. I can write illegibly, but I cannot make myself sound like a secretary. It is like the swagger sticks all over again; those who feel the need to sign their names so that you cannot read them, may do so.

—F.C.

ORIGINAL ARTICLES

Cancer Genetics, Part IV: New Methodologies*

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New Methodologies

NEWLY developing research methodologies are making it possible to determine the existence of identifiable biological determinants in patients with certain genetic and/or cytogenetic disorders associated with cancer susceptibility. For example, through the use of such oncogenetic viruses as SV40,[1-9] human cells in tissue culture can be transformed into neoplastic cells.[2,3] Quantitative assay methods are now available for estimating the frequency of transformation for a particular cell strain; thus, cells from individuals with certain genetic anomalies who show a high risk for cancer have in turn shown increased frequencies of transformation of cells following infection with SV40. These have been confirmed in fibroblasts from patients with Down's syndrome,[3,4] Fanconi's anemia,[5,6] Klinefelter's syndrome,[7] and from a patient with XY-gonadal dysgenesis.[8] These methodologies have also been applied to members of certain cancer-prone families,[9] to patients with cancer of the colon,[10] and to patients with acute myelogenous leukemia[11] among whom a variable range of transformation was observed. These findings suggest that transformation frequency determination might harbor a powerful potential for the detection of individuals who are genetically predisposed to cancer, and thereby enable the physician to use this information profitably for closer surveillance of his patients in order to achieve earlier cancer diagnosis.

The oncogene theory[12,13] hypothesizes that quiescent genes present at conceptus are subsequently triggered by certain outside "signals," i.e., hormones, environmental chemicals, X-ray, solar radiation and countless other potentially incriminating carcinogenic events, to produce uncontrollable cellular reproduction and tumor formation. Thus, these environmental factors, appearing during critical periods of growth and development, activate genes which turn cells in a specific target organ into a cancer cell. This theory could also explain the differing tumor aggregations in specific hereditary cancer problems. Thus, when "genetic" factors are discussed in differing contexts we wish to admonish the reader to consider the fact that genes may be influenced to a variable degree by other nongenetic factors, including oncogenic viruses. Thus, the issue of genetic etiology is an exceedingly complex one, and demands a broad and eclectic approach if we are to make significant progress in this discipline.

Experiments in Allophenic Mice: Cancer Genetic Implications

We have already emphasized the fact that practically every inbred strain of mice shows a characteristic profile of malignant neoplasms wherein breeding experiments have strongly suggested that the susceptibility to most of these tumors is probably polygenic. Nevertheless, the basic mechanisms involving genetic factors in cancer research remain unclear.

While considerable information has been obtained relevant to genetic factors in cancer through *in vitro* studies, it is reasonable to assume that additional answers in the area of cancer genetics might ultimately be found through *in vivo* studies involving the growth of tissues within the context of the dynamically integrated and functioning organism so that interactions between tissue systems can be critically analyzed. Thus, questions pertaining to cancer susceptibility relevant to whether the carcinogenic events

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are initiated on a local level in a particular tissue or whether it is from some generalized aberration within the organism can be more profitably pursued. It is in this area that the utilization of allophenic mice have proven to be most useful, especially in testing hypotheses pertaining to whether specific genetic loci influence vulnerability to tumors through selectively expressing this susceptibility in specific tissues. Thus, manipulation of cellular genotypes in terms of high and low susceptible cellular genomes through their differential distribution among tissues has been developed to provide answers to these questions.

Mintz[14] has pioneered in the development of a novel form of mammalian genetic manipulation which has opened new horizons for *in vivo* studies of the genetic basis of neoplasia through the development of a laboratory artifact, namely, the allophenic mouse. The allophenic mouse is a genetic mosaic produced by aggregating the blastomeres of two embryos with differing genotypes into a single cluster during cleavage stages. This complex is then implanted into the uterus of a surrogate mother. Surviving embryos result in a living adult mouse with cells which harbor immunogenetically distinct constitutions and which coexist in the living animal. Thus, the allophenic mouse ". . . contains different phenotypic subpopulations of cells, because of dissimilarities in cellular genotypes. One such animal has four (or even more) parents instead of two, since it is derived by joining together two (or more) cleavage-stage embryos in vitro, each with its own set of parents and thus its own genetic constitution. About a third of all the artificial composites, after transfer to an incubator mother, continue their development to birth and become healthy, long-lived adults. Since the birth . . . of the first mosaic mouse, over 1,000 quadriparental individuals had been produced and have survived (in Mintz's laboratory). The two different cellular genotypes can be found in any or all tissues, because of the early stage at which the cells are aggregated. In addition, the total level of retained mosaicism, and the tissue distributions and proportions of the respective genotypes, vary greatly from one animal to another, even within the same paired combination . . . Allophenic animals are permanently immunologically tolerant of any immunogenetic differences in their component cells and have never developed runt disease. They nevertheless possess full immunological competence to respond to and reject 'foreign antigens' such as skin grafts of another histocompatibility type."

Thus, utilizing allophenic animals it is possible to experiment with this system so that cells from a high-tumor strain can now be made to co-exist with cells of an unrelated low-tumor strain, starting prior to cell differentiation. The permutations and combinations in tissue distributions of cellular genotypes constitute the experiment. The animals bring to light those biological relationships that are relevant to genetic control of tumor susceptibility and to the progress of malignancy and metastasis.

Thus, Mintz has been able to conduct numerous experiments on a variety of tumors for which there is evidence of genetic predisposition. Her aims in these experiments were to identify whether the heredity of the potentially malignant cells, of other organs, or of the host as a whole, is responsible for susceptibility; and, ultimately, to define in molecular terms the means by which the susceptible cell phenotype is produced. Studies using this system were made on allophenic mice and reveal that the high-tumor disease history of the allophenics was consistent with the composition of their tumors.

Studies showed that loci controlling susceptibility to mammary tumors appear to express themselves chiefly in the mammary gland cells themselves and those controlling susceptibility to hepatomas become active mainly in liver cells. Intracellular rather than intercellular events seem paramount in the origin of these specific histologic varieties of cancer.

The allophenic mouse model also has implications for virological experiments. For example, according to Mintz,[14] "Gene control of susceptibility to viral tumors may also involve a significant measure of control of

viral infectivity via the target cell itself, depending upon the cellular phenotype. Allophenic mice afford new avenues for genetic analysis of this possibility in vivo under conditions in which genetically different cells are exposed to the virus within a shared set of systemic influences."

This novel method merits continuing attention as we search for clues to the role of genetics in carcinogenesis.

Biological Correlates With Cancer

Inquiry into the identification of potential biological correlates with cancer have been popular for several decades, though unfortunately, to date, their significance and utilization has been limited. We shall limit our discussion to only three of these methodologies, namely blood group antigens, Australia antigen, and HL-A histocompatibility antigens.

The ABO Blood Groups and Cancer Associations

The search for a possible etiologic relationship between ABO blood groups and cancer was initiated through the studies of Buchanan and Higley[15] in 1921, in the same year, by Alexander[16] and by Johansen in 1925.[17] In 1953, Aird and associates[18] were probably the first investigators to demonstrate a significant association between gastric carcinoma and blood group A. This observation was verified by other investigators who also confirmed a statistical association between blood group A and pernicious anemia.[19-21] Interestingly, blood group A has also been found to be statistically associated with carcinoma of the genital tract,[22] tumors of salivary gland tissues in general,[23] and with mucinous secreting tumors in particular.[24] Blood group A has also been shown to be associated with multiple primary malignant neoplasms.[25] While blood group A is seemingly the most frequent blood group antigen associated with cancer, there is evidence showing that a classically inherited (autosomal recessive) precancerous disease, namely xeroderma pigmentosum, has a statistical correlation with blood group O.[26]

Recently, Marcus[27] has updated this entire subject and expanded it to include other diseases in addition to cancer and has discussed existing knowledge of the biochemistry, genetics, and physiologic factors relevant to the ABO and Lewis blood group systems and their associations with human disease.

When considering non-cancerous diseases, we find that diseases such as duodenal ulceration show a high statistical association with blood group O;[21] in turn, duodenal ulceration is also more likely to occur in nonsecretors of blood group substances than in secretors.[28] Other investigators[29, 30] have demonstrated that blood group O patients have an excessive rate of bleeding, perforations, and stomach ulcers. These complications were not found to be correlated with secretor status.

Other cancers showing increased associations with blood group A include cancer of the ovary[22, 31] cancer of the pancreas,[32] prostate,[33], gallbladder,[34] and lip.[35] Astrocytoma of the brain, particularly when the patient is less than 20 years of age, was found to show a statistical association with blood group O.[36] Interestingly, in face of the preponderance of blood group A and its association with a variety of cancers, Clifford[37] found that in Kenya, patients with blood group A were seemingly at low risk for nasopharyngeal carcinoma.

Buckwalter and associates[38] found a correlation of blood group O with lung cancer though other investigators[16, 39, 40] were not able to find any blood group association with lung cancer. Other tumors lacking significant correlation with blood group antigens have included cancer of the colon and rectum,[33, 38] esophagus,[32, 35, 41] larynx,[42] liver,[43] tongue,[35] uterus,[44] and chromophobe adenoma.[32]

Lee[45] reviewed the literature on blood group associations in cancer of the uterine cervix, endometrium, and breast, and concluded that the results in these particular tumors were too conflicting to arrive at any conclusive impressions so far as blood group antigens and their association with these diseases were concerned.

The study of blood group antigens and their associations with cancer nevertheless harbors a research potential for cancer epi-

demiologists and for geneticists. Some of the problems encountered in these studies perhaps have been compounded by the profound racial admixtures in many populations with concomitant variable assortments of blood group antigens, problems in statistical sampling of the populations, and of course, the ever present problem of laboratory error in assessment of blood group antigens as well as inadequate histologic evaluation of malignant neoplasms. These problems notwithstanding, the full etiologic meaning of the mentioned associations of blood groups with malignancies is unclear. Thus, Buckwalter comments as follows: "The full implications of the observed association remain to be realized. Interested clinical and basic scientists alike have regarded this association as perhaps the frontier of a new field of investigation, development of which may lead to an understanding of fundamental considerations having to do with the cause of gastric cancers, cancers in general, and the broader aspects of heredity and disease.[19]

Australia Antigen (Au [1] or HAA)

In 1965, Blumberg and associates[46] described a "new" antigen in the serum of patients with leukemia, now referred to as Australia antigen. Since this report numerous investigations have been conducted upon this antigen from the standpoint of its epidemiology, genetics, and its physical and chemical characteristics. The first significant epidemiologic clue about the antigen was that it was either closely associated with or possibly could be a causal agent in viral hepatitis.[47, 48] Indeed it is estimated that millions of asymptomatic patients harbor this antigen, as "carriers."[47]

The Australia antigen was first found in the serum of an Australian Aborigine and hence it has been referred to as Australia antigen (phenotype Au [1] and also as hepatitis associated antigen (HAA).

The Australia antigen is relatively rare in normal individuals in the United States occurring only in about 1 in 1,000 normal people; however, it occurs in about 27% of persons with acute viral hepatitis (post-transfusion hepatitis, 41%; infectious hepatitis, 22%).[47, 48] On rare occasions the antigen disappears with clinical improvement. Other terminology for this antigen has included, "SH antigen" which is identical with the Australia antigen.[49]

Under electron microscopy it has been observed that the antigen is a particle of about 200 Angstroms in diameter which contains knoblike subunits on its surface. This approximates the suspected size of the hepatitis virus.[49]

The antigen has been observed in patients with Down's syndrome in which interesting variations of its prevalence are found based upon the type of ascertainment. For example, the antigen is found in about 30% of institutionalized (large institutions) patients with Down's syndrome; contrariwise, the antigen is extremely rare in other mentally retarded patients in the same institution and is almost uniformly absent in the employees.

In contrast with the institutionalized Down's syndrome patients, the antigen is infrequently found in outpatients with Down's syndrome and it is also rare in patients with Down's syndrome found in small institutions. This has led to the impression that a host factor in patients with Down's syndrome results in a high susceptibility to chronic infection with the Australia antigen.[49]

Data from other areas of the world show varying frequencies of Australia antigen. Thus, it is present in about 3% of Indians from south India, 6% in Viet Namese, and 6% in Filipinos.[49] In addition, a family study in Cebu, in the Phillipines and another in Bougainville Territory in New Guinea revealed familial clustering of the antigen consistent with inheritance of the trait as an autosomal recessive.[47]

Patients with Down's syndrome and Australia antigen have been found to have moderate increases in serum glutamic pyruvic transaminase (SGPT) and liver biopsy has shown evidence of chronic hepatitis.[49]

Of additional interest, Australia antigen has been shown to occur in excess in affected individuals in families with familial crypto-

genic cirrhosis, and in two families with multiple occurrences of chronic liver disease and hepatoma.[50] Denison and associates[51] have also presented an example of familial hepatoma with Australia antigen and Bancroft and associates[52] described a family with hepatitis and Australia antigen. Finally, Ohbayashi has presented the combined results of a study of three families[53] which has included a new family in addition to the two families they previously studied.[51]

The study by Ohbayashi and associates[53] is based on sera from 54 persons from three families noteworthy for increased occurrences of chronic liver disease and hepatoma. Australia antigen and the antibodies against Australia antigen were tested through the use of the immune adherence hemagluttination method. Results showed that Australia antigen was positive in 14 (93%) out of 15 of the affected members and their siblings and this antigen was also positive in 20 (83%) out of the 24 children of the female siblings. These findings were contrasted with the fact that Australia antigen was negative in seven out of the eight children of the male siblings and it was also negative in six spouses of the siblings that were tested. Anti-Australia antigen was detected in only one of the wives of the Australia antigen positive males.

Conclusions drawn from these families as well as from a review of familial cirrhosis from the Japanese literature suggested that in certain kindreds, Australia antigen or an Australia antigen-infectious agent is transmitted from mother to child and is also responsible for the development of the carrier state, chronic hepatitis, cirrhosis of the liver, and eventual development of hepatoma.

HL-A System in Human Cancer

Antigens of the HL-A system are widely distributed throughout the body and are under genetic control by two linked loci which are believed to be located adjacent to a separate locus that controls the mixed lymphocyte reaction.[54] The HL-A system is of crucial importance in influencing histocompatibility reactions in man.

This system harbors a potential for the study of genetic linkage of histocompatibility antigens to cancer. This could prove to be of clinical value should certain HL-A antigens be found to correlate with findings of histologically confirmed cancer or with patients who are genetically susceptible to cancer by pedigree evaluations; and contrariwise, it would be of equal interest should large numbers of patients who are free of cancer, or who come from families noteworthy for a paucity of cancer, have specific HL-A antigens in common. Thus, the method would have merit in identifying cancer prone or cancer resistant histocompatibility antigens in these respective clinical categories. However, too few population and family studies have been performed to glean meaningful results.[55]

As in so many other investigations in cancer genetics, animal studies have provided an initial stimulus for developing methods for later application to humans. Hence, initial interest in the distribution of HL-A antigens in patients with cancer stems primarily from the demonstration of an association between the major histocompatibility system of mice (H-2) and susceptibility and resistance to certain forms of leukemia.[56]

Several differing types of human cancer have been studied including choriocarcinoma,[54, 57] Hodgkin's disease,[58] and other lymphoid tumors in general.[59] Several suggestive associations have been made with these various cancer problems, but it is too early to establish a precise cause effect type of correlation between HL-A types and specific varieties of cancer. For example, in the case of Hodgkin's disease an increased incidence of HL-A5 has been shown by some investigators;[58] and in acute lymphatic leukemia of childhood an increased incidence of HL-A2-12 has been identified.[60] Our own studies of the cancer family syndrome are too preliminary for definitive analysis, though we have identified a slight trend in the direction of HL-A2-12 in patients who have either had cancer or who are at genetic risk for the development of cancer.

The primary importance of the utilization of the HL-A system in human cancer genetic studies appears to rest in the potential it harbors for linkage studies for defining risk factors for cancer susceptibility. Since

a reliable marker indicating cancer proneness is virtually lacking at the moment it will behoove us to continue to add to the body of accumulating knowledge about the HL-A system in the hope that it might prove of value as an adjunct to cancer genetic investigations.

Summary

These discussions of methodologies in cancer genetics disclose increasing interest in the identification of constitutional parameters which might explain variations in host resistance and susceptibility to cancer. Herein resides a powerful potential source of information about carcinogenesis in humans.

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Unexplained Congestive Heart Failure — Value of Echocardiography in Detecting Correctible Disease*

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WE were recently shown the heart of a man in his fifties, who had died with the clinical diagnosis of chronic atrial fibrillation and severe congestive heart failure of undetermined etiology. Postmortem examination revealed a large secundum atrial septal defect. Therefore, we would like to emphasize that now there is available a nontraumatic, noninvasive technique, i.e., echocardiography, that is an extremely valuable screening tool for separating patients with an atrial septal defect from other patients with chronic congestive heart failure secondary to the usual causes, i.e., coronary artery disease, hypertension, cardiomyopathy, rheumatic heart disease.

To illustrate the value of echocardiography as a screening tool, we will describe a case in our experience which was extremely confusing until an echocardiogram was performed.

> A 65-year-old white male presented with a clinical picture of severe right-sided fluid retention of 1 month's duration. He had no previous history of chest pain, myocardial infarction, or congestive heart failure. Physical examination revealed evidence of anasarca, with marked elevation of the jugular venous pressure, a moderately enlarged liver, and marked pretibial-thigh-and scrotum edema. He subsequently underwent a 30-pound diuresis. The rhythm was irregular, and the electrocardiogram showed atrial flutter with a variable AV block. The second heart sound was persistently split on full expiration, but the heart sounds were somewhat faint and difficult to hear. A third heart sound gallop was present in early diastole. However, no murmur was heard at any time in either systole or diastole. The electrocardiogram suggested severe right ventricular hypertrophy, with a qR complex in leads V3R and V1. The initial clinical impression was either severe silent mitral valve stenosis or an idiopathic cardiomyopathy. However, an echocardiogram revealed a normal mitral valve motion, normal left atrial and ventricular size, a markedly enlarged right ventricular size, and paradoxical motion of the interventricular septum. Subsequent cardiac catheterization revealed a large left-to-right shunt of 44% across an atrial septal defect. He was also demonstrated to have moderate arteriosclerotic coronary artery disease with a 70-75% stenosis of the proximal left anterior descending coronary artery, 80-85% stenosis of the nondominant left circumflex coronary artery, and two long areas of 60% stenosis in the dominant right coronary artery. Also, the left ventriculogram was abnormal with a hypokinetic anterior wall. Open heart surgery was subsequently accomplished, with closure of the atrial septal defect, in combination with construction of a saphenous vein graft to the left anterior descending coronary artery.

Therefore, this patient initially presented with the clinical problem of congestive heart failure of unexplained etiology. Several clinical clues were present to suggest the diagnosis of an atrial septal defect, includ-

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ing a fixed split second heart sound, electrocardiographic findings of atrial flutter plus a right ventricular conduction delay, and a compatible chest x-ray which showed moderate cardiac enlargement, dilatation of the main pulmonary artery, with no left atrial enlargement. The peripheral lung fields did not suggest an increased pulmonary blood flow of a left-to-right shunt, which is commonly the case in adults. Of course, it should be emphasized that a fixed split second heart sound is not diagnostic of an atrial septal defect, because right bundle-branch block alone can sometimes create this finding. The major misleading finding was the absence of any heart murmur. In patients with a significant sized atrial septal defect, there usually is a systolic murmur at the upper left sternal border, ranging from Grade I-IV/VI in intensity, usually crescendo-decrescendo in shape, but at times may be described as "superficial," or "scratchy." No similar case has been found in the world literature of a large atrial septal defect without a flow murmur across the pulmonic valve. However, after the echocardiogram demonstrated a normal mitral valve, normal left atrial and left ventricular size, a greatly enlarged right ventricle, in combination with paradoxical interventricular septal motion, the clinical suspicion of an atrial septal defect was aroused, and cardiac catheterization confirmed the echocardiographic diagnosis.

This noninvasive technique of echocardiography in the diagnosis of heart disease has only been popularized in the last five years.[1] The technique involves placing a transducer with a piezoelectric crystal along the left sternal border, and rotating the transducer in several different directions in order to scan over several structures of the heart, including the posterior left ventricular wall, anterior and posterior leaflets of the mitral valve, left atrium, interventricular septum, ascending aorta, and right ventricle. The characteristic findings of an atrial septal defect are an enlarged right ventricular size in combination with paradoxical motion of the interventricular septum.[2] This is actually not diagnostic of an atrial septal defect, but only of volume overload of the right ventricle; but other causes, such as tricuspid insufficiency, can be excluded by clinical examination.

Much emphasis has been placed on the diagnosis of an atrial septal defect in this paper because it is the most frequent form of congenital heart disease discovered in adults. The proper diagnosis may go unrecognized for many years, because clinical symptoms may be entirely absent and physical signs subtle. However, practically all patients with atrial septal defects who survive to age 50 years are symptomatic.[3] Older patients develop symptoms primarily due to left ventricular failure, and/or the development of atrial arrhythmias, especially atrial fibrillation and atrial flutter. Therefore, in the older age group, when unexplained atrial arrhythmias develop, an atrial septal defect should always be looked for and excluded. Generally, the clinical suspicion of an atrial septal defect is created by finding a systolic murmur at the upper left sternal border in combination with a fixed split second heart sound. But as shown by our case, a systolic murmur may not always be present.

Other causes of unexplained congestive heart failure in which correctible disease may be overlooked clinically and be detected by echocardiography include: (1) Mitral valve stenosis, in which case sometimes the low pitched diastolic rumble present at the apex can only be heard with use of the bell of the stethoscope in the left lateral decubitus position. In addition, in the presence of significant pulmonary hypertension and low cardiac output, a diastolic murmur may be totally absent. (2) Pericardial effusion, in which case a fluid layer can be demonstrated surrounding the heart. This is of particular value in the patient with an unexplained cardiac enlargement, since the usual forms of congestive heart failure can be shown to have an enlarged left ventricular size in the absence of pericardial effusion.

The other common clinical indications for performing echocardiography in the adult are the following: (1) Exclude a left atrial thrombus or tumor, especially with a history of a previous systemic embolus. How-

ever, it must be emphasized that in the presence of an unexplained systemic embolus, that suspicion of a paradoxical embolus across an undiagnosed atrial septal defect must also be considered. (2) A screening procedure for diagnosing idiopathic hypertrophic subaortic stenosis, with its abnormal septal thickness and abnormal systolic anterior movement of the anterior leaf of the mitral valve. (3) Document posterior mitral leaflet prolapse in the midsystolic click, late systolic murmur syndrome. (4) Separate ruptured chordae tendineae to the posterior leaflet of the mitral valve from the usual rheumatic mitral insufficiency. (5) Separate the diastolic Austin-Flint murmur associated with severe aortic insufficiency from true mitral valve stenosis. In other words, echocardiography could confirm or disprove both aortic and mitral valve involvement.

Finally, we would like to emphasize one final point about our particular case — a moderate degree of left ventricular dysfunction was demonstrated by left ventricular angiography. No reports are available in the literature concerning selective coronary arteriography and left ventricular angiography in adults with atrial septal defects. The most recent data on ventricular function and atrial septal defects was published in 1970. Flamm et al measured left ventricular end diastolic pressures at rest and following exercise.[4] They concluded that the left ventricular dysfunction was most likely secondary to generalized myocardial involvement, since in their patients left ventricular failure occurred only in associated with, and probably subsequent to, right ventricular failure. Our experience in this one case suggests that in the adult, subclinical arteriosclerotic coronary artery disease is more likely the primary etiology.

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Neurologic Worm Diseases

PART III

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Alveolar echinococcus disease (due to *E. multilocularis)* must be differentiated from the species *E. granulosus,* described in detail previously. Most frequent in southern Germany, Switzerland, the Tyrol (Austria), and the USSR, it is found in many other locations in Europe as well as in Latin America, Australia and New Zealand. Occasional foci are known also in western Canada, Alaska, Turkey, and even in the U.S. (North Dakota). It is a worm of temperate and northern climates. Man is infected from fox or other canine feces by direct contact with polluted ground or by way of fruit, berries, nuts, or vegetables contaminated with ova. The liver essentially is involved by larvae which honeycomb it with irregular, multilocular cysts. The clinical picture is slow in evolution and progress, revealing hepatic disease with hepatomegaly, then icterus, and finally intrahepatic portal hypertension and ascites. It resembles the slow extension of an intrahepatic carcinoma. Clinicians and pathologists unfamiliar with this disease commonly do not recognize the specific diagnosis, even at postmortem examination.

Neurologic involvement is a great rarity, but one of three well documented cases with neuropathologic confirmation revealed a cerebellar cyst, another a lesion in a cerebral peduncle, the third an intracerebral focus.

Fascioliasis is due to *Fasciola hepatica.* Most cases of human infection are reported from Latin America, France, and Mediter-

ranean countries. Food (vegetable and fruit) preparation and hygiene are important factors. However, this fluke has a worldwide distribution, particularly where farm animals (especially sheep), low wet pastures, snails, and plentiful rainfall are present. It has been reported, also, in the West Indies, the Near East, the USSR, Poland, S.E. Europe, England, South Africa, China, and Hawaii. It is occasionally found in animals in southern, western and north-central U.S.

Reservoir hosts are commonly sheep, but cattle, goats, hogs and wild herbivorous mammals may serve likewise. These animals and man are infected by consuming moist, unclean vegetation (for humans, lettuce and watercress are common) or drinking contaminated water. The ingested larvae (metacerceriae) migrate through the upper intestinal wall to settle mostly in biliary passages, where they grow to maturity in three to four months. Ova then pass in feces of the host. In water, ova hatch, larvae invade snails and mature further, eventually leaving the snails (still in a larval state) to live free in water, on aquatic vegetation or bark until a mammalian host consumes them. It is possible, also, that besides snails, fish, and crustaceans may be infected, and that human contamination may occur directly from handling or eating these insufficiently cooked.

Worms remain in bile ducts and liver especially, but the extent of injury depends much on the number of worms. Larvae migrating in the abdominal cavity may wander to unusual sites to lodge, where chronic abscess or fibrosis develop. This may be in a blood vessel, lung, subcutaneous site, or orbit, rarely even the brain.

Symptoms will include acute, subacute, and chronic states of hepatitis, biliary tract inflammation and obstruction, malaise, generalized allergic reactions, fever, and diarrhea. Right upper quadrant abdominal pain and hepatomegaly are common.

Neurologic features are not common, but have been recorded a number of times, especially in French literature. Most accounts are based on clinical presumption, the patient revealing usually acute cerebral disturbance in the course of proven fascioliasis and other causes of cerebral symptoms variously excluded. Most often described are patients with acute focal cerebral symptoms (suggesting mass lesion, focal encephalitis or infarction). Eosinophilic meningitis, cranial nerve paralysis (especially VI and VII), and acute paraplegia are also recorded. Neuropathologic documentation is not found, with the exception of one report from Argentina (Ruggieri, F. et al, 1967). This describes a 44-year-old female with recent onset of headache, convulsions, and aphasia, found to have a left temporal (intracerebral) mass, a cyst with ova of F. hepatica in it.

Eosinophilia is present in 40 to 60 percent of patients. Ova are present in stools or in duodenal or biliary drainage. Sedimentation rate is elevated, enzyme tests of liver damage pertinent, and serum bilirubin levels may be raised. Skin and complement fixation tests are valuable. Cerebrospinal fluid should be examined, also, for eosinophilia.

A diagnostic-therapeutic test with chemotherapy may permit presumptive diagnosis. Effective chemotherapy is available with emetine hydrochloride. Chloroquine has also been used. Corticosteroids may allay allergic and inflammatory features.

Loaiasis (Loa loa worm) is common in equatorial west Africa and southern Sudan. Hosts are human and simian. Individuals are innoculated with larval microfilariae by the bite of the mangrove fly (Chrysops genus). Mature worms reside in subcutaneous tissues, where they produce migratory swellings ("Calabar swellings") episodically. These may appear in ocular conjunctiva. Acute episodes of generalized allergic reaction occur.

Neurologic features are uncommon. Intense microfilaremia or too rapid chemotherapy may result in meningoencephalitis, which carries a high mortality. Neuropathology discloses diffuse microgranulomatous encephalitis, with microfilariae in considerable numbers. Isolated peripheral nerves may be affected by adjacent Calabar swellings.

Diagnostic laboratory aids disclose eosinophilia and microfilaremia. Immunologic

tests are available. The adult worm from incised subcutaneous swelling may be identified. Patients with cerebral implication often disclose mild to moderate pleocytosis and increased protein of cerebrospinal fluid. Microfilaria per se in spinal fluid is of little neurologic diagnostic value, as it may appear also in symptom-free patients.

Specific chemotherapy using diethylcarbamazine is effective, but requires caution, especially in patients with high microfilaremia. In the first 72 hours of therapy, acute allergic and toxic effects of killed microfilariae may overwhelm the patient. Exchange transfusion may be used to reduce high microfilaremia before starting chemotherapy.

Bancroft's filariasis, due to Wuchereria bancrofti, is found in tropical and subtropical climates, where mosquitoes are common, from 41° N to 28° S latitude in the eastern hemisphere, from 30° N to 30° S in the western hemisphere. It is highly endemic in South Pacific Islands, Fiji, Burma, India, coastal Arabia, and across tropical Africa. It is common along the northern coast of South America, coastal Central America, and the West Indies.

This filariasis is transmitted from man to man by mosquito bites. The mosquito is infected with microfilariae (larval forms) of W. bancrofti from man and infects the subsequent human it bites. The microfilariae settle in lymphatics, mature over 12 or more months, then produce more microfilariae, which disseminate in blood stream and lymphatics. Chronic inflammation and fibrosis occur in lymphatics, producing recurrent or chronic lymphangitis and lymphadenopathy in limbs and scrotum especially. After two to seven years, there may develop lymph stasis, swelling, and elephantiasis. Periods of intense microfilaremia may occur. Deposition of worm or microfilaria in eye and pericardial effusion have been recorded rarely.

Diagnosis comes to mind with the following observations: geography, mosquitoes, lymphangitis, biopsy of enlarged lymph node (worms or microfilariae), immunologic tests, microfilariae in night blood sample, and later x-ray evidence of multiple calcified, thread-like worms in lymphatics; response to specific chemotherapy.

There are very few convincing reports of neurologic involvement, most of which are based on clinical evidence with other possible etiologies of the cerebral disorder presumably eliminated. With microfilaremia common in endemic areas, the possibilities of a second diagnosis must be considered. However, acute and intense bouts of microfilaremia conceivably could produce microischemia in cerebral capillaries. Acute, diffuse or focal encephalitis, cerebral edema and subarachnoid hemorrhage have been ascribed to acute filariasis. Considerable hyperfilaremia accompanies this, and in some instances response to antifilarial chemotherapy is considered diagnostically significant. Microfilaria in spinal fluid does not appear of diagnostic value (neurologically), as this is not an unusual finding in asymptomatic patients. The rare neuropathologic report cites microfilaria in inflammatory foci, in Virchow-Robin spaces, and cerebral edema.

Specific and effective chemotherapy is available in diethylcarbamazine or intravenous naphuride sodium (Suramin). Uncommonly, cerebral symptoms have been ascribed to initiating too vigorous chemotherapy, with rapid death of high numbers of microfilariae. Use of corticosteroids and less rapid initiation of treatment would be advisable under these circumstances.

Onchocerciasis is common in tropical Africa and Latin America (especially in western Guatemala, southern Mexico, northern Venezuela and Colombia). Embryonic worm forms (microfilaria) are transmitted from man to man by the bite of the black fly, genus Simulium. With maturation, adult worms settle in a tight coil in subcutaneous nodules of pea-egg to pigeon-egg size. These begin to appear 6 to 12 months after innoculation. Especially in Latin America, these nodules may appear in the scalp (especially temporal or occipital sites), where they erode the external table of the cranium sufficiently to be seen in skull films. Later, the female worm discharges embryonic forms

(microfilaria) from these nodular foci into lymphatics and wide migration. These occasionally result in a minor form of elephantiasis (inguinal, genitalia). More critically, they commonly invade the eye. Microfilariae invade the cornea, orbit, and vicinity of the optic nerve. Uveitis and retinitis ensue, and, in final stages, microfilariae invade the optic nerve. A small incidence of chiasmal arachnoiditis and cerebral edema has been blamed on onchocerciasis, but reports are based on clinical presumption. Convulsive disorder without other indications of progressive cerebral disease is said to occur too frequently with onchocerciasis to be considered coincidental (Haseeb, M. A. et al, 1962).

Diagnosis is usually readily established by skin snip biopsy which reveals microfilariae. Chemotherapy (diethylcarbamazine for microfilariae, Suramin for adult worms) covered with antihistamine is effective. Surgical removal of worms from nodules is commonly advised.

Dipetalonema (Acanthocheilonema) perstans exists throughout the tropical world, especially in Africa, including Algiers and Tunis, coastal South America from Venezuela to Argentina, Panama, Surinam, and Trinidad. Native populations in some parts of Africa are 90 percent infected. In Africa, many patients also have Bancroftian filariasis, loa loa, and other worm infections.

Man is an important definitive host, infected by mosquito bite. The adult worm lives in pleural and peritoneal cavities. This infection is seldom symptomatic in native black populations, and may be only minimally or rarely so in others. Variously transient swellings, pericarditis, conjunctivitis, allergic reactions, a variety of pains, hepatitis, arthritis, exhaustion, and irritability have been ascribed to D. perstans. Eosinophilia appears in 70 percent of patients. Diagnosis is ascertained by finding microfilariae in blood. There are three presumptive clinical presentations in the literature of the past decade describing acute meningoencephalitis and acute encephalomyelitis associated with D. perstans infection in Africa. Microfilaria were found in cerebrospinal fluid (although in other microfilarial states, such as loa loa and Bancroftian filariasis, this finding is noted also in neurologically asymptomatic patients). No neuropathologic studies have been reported. Chemotherapy is effective with diethylcarbamazine or Melarsen.

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Medical Students and Future Membership In Organized Medicine

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THE older physicians in the field of organized medicine, members of the county medical societies, the Nebraska Medical Association, and the AMA have wondered for several years why the medical students and some of the house officers seem to be turned off and are not joining the medical organizations in droves as they did during the time when we were just going into the field of medicine. It must be pointed out that in times past very frequently it was a requirement in order to belong to the staff of a hospital that one become a member of the county society. This is no longer true, because the courts have found that membership in a medical society or association is in no way an assurance of the superiority of the medical caliber of the physician, and therefore this particular clause was removed from the charter of many hospitals. The need for joining medical societies then

became less urgent to the younger men, and the many obvious values which you and I see are not now obvious to them. The fault is not theirs, it is ours.

The vast changes that are taking place in the relationship of the practice of medicine to the patients, the government and the third party carriers make it more important now for medical students to belong to organized medicine than ever before in the history of medical practice. Yet the medical students have stayed away in droves. Why? The real reason is that there really has been no extended effort on the part of the members of the organization to let medical students know exactly what is to be gained by joining an organized medical society.

It has been learned invariably that when the student was thoroughly exposed to the society or association or both, more frequently than not he became an enthusiastic supporter for joining the organizations. When one asks the medical students today why he has joined or why he is not interested the common answer is: "No one has told us anything about it, and all of the impressions that we have are from disgruntled individuals or from the press which has not been very favorable towards medicine." They do not have contact with the patients for whom we care, and therefore they do not know how our true friends feel about us.

I believe that a very, very concerted effort should be made in both medical schools at the earliest possible moment to work with the administration of the schools to set aside a day in which the many advantages of the organized medical groups can be explained to the students. I believe that it would be wise, also, to consider making it possible for health insurance to be obtained for them through a group plan in the medical association, just as the dental association has provided for dental students. Many of the students are married and have responsibilities, and every one knows how short of funds the medical student is. The very fact that they could get coverage with insurance could be a tremendous incentive for these young men to become interested in our medical organizations.

Once the students are exposed they can see that organized medicine is not devoted solely to socioeconomics, that it is much more important because of its post-graduate teaching position, helping to support medical students going through school, and most of all because it enables the young man to come in close contact with the physicians who are designing and helping to design the future that these young men are going to have to endure.

So let us get on the ball and see that *these* young men, at least, do not stay away from medical organizations by default. Let us carry out our responsibilities and see that they know exactly what the organizations are. One way of accomplishing this is to bring a medical student to your local medical society for every meeting. The more they are in contact with us, the more they will know us, and the more incentive they will have to become members of our organizations.

Methods to Gain Access to the Blood Stream for Hemodialysis*

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ACUTE and chronic hemodialysis has been progressing rather rapidly with the development of efficient methods to gain access to the blood stream. Evidently, until 1960 hemodialysis was used only for acute patients with reversible renal failure or to assist patients in chronic renal failure during medical emergencies, employing repeated cutdowns to gain access to the circulation.[4, 5]

In this report, experience with different techniques to gain access to the blood stream for hemodialysis at the Deaconess Hospital Dialysis Center, Buffalo, New York; and Veterans Administration Hospital, Lincoln, Nebraska, are presented.

Results: External radial arteriovenous shunts by means of the conventional teflon-silastic prosthesis as described by Quinton and associates[7] were used exclusively at the Veterans Administration Hospital Dialysis Unit, Lincoln, Nebraska, and the experience with this technique from March 1957 to December 1970 is reported (Table 1). External shunts were surgically created in 20 patients to perform 2,005 dialysis constituting an experience of 11,800 hours of hemodialysis. In 33 instances, new shunts were constructed due to failure of former shunts to function properly, and in 48 instances revision of these shunts was done in the operating room to improve blood flow. The number of declottings were not properly recorded but undoubtedly accounted for most of the hospitalizations.

Table 1
EXTERNAL ARTERIOVENOUS SHUNTS
Veterans Administration Hospital, Lincoln, Nebraska
March 1957 - December 1970

No. of patients	20
No. of shunts	53
No. of dialysis	2,005
Hours of dialysis	11,800
Failures	33
Shunt revisions	48

Radial arteriovenous fistulas as described by Brescia and associates[2] are used exclusively for patients admitted to the Deaconess Hospital hemodialysis program, Buffalo, New York. From May 1, 1966 until April 1, 1970 54 radial arteriovenous fistulas were constructed in 49 patients treated biweekly for hemodialysis (Table 2). A total of 3,851 dialyses were performed, requiring about 8,000 venipunctures totaling more than 23,000 hours of dialysis in patients in end-stage chronic renal failure. There were seven failures in this group. In 3 patients, the created fistulas never functioned because of surgical failure, and in one patient septic aneurysm developed at the surgical site. In three other patients, thrombosis of the fistula occurred after some use. Five of the above failures required new fistulas and no further complications were experienced. One patient had severe sclerosis involving radial and cubital arteries, and saphenous vein bypass between brachial artery and

Table 2
INTERNAL RADIAL FISTULAS
Deaconess Hospital, Buffalo, New York
July 1966 - April 1970

No. of patients	49
No. of fistulas	54
No. of venipunctures	8,000
No. of dialyses	3,851
Hours of dialysis	23,000
Failures	7

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distal cephalic vein was the only procedure possible. The remaining patient was dialyzed by repeated percutaneous femoral vein catheterization.

The surgical technique for the construction of fistulas was first described by Brescia and associates.[2] Briefly, a side-to-side anastomosis between the radial artery and distal cephalic vein is performed on the dorsum of the wrist, preferably under general anesthesia or brachial block. The venotomy and arteriotomy incision is limited to approximately 0.5 cm. The fistula is not used for dialysis for 7-10 days following its creation.

Percutaneous transfemoral vein catheterization following the Seldinger technique[9] employing the Shaldon catheter[10] was performed in patients requiring temporary hemodialysis for acute conditions as well as in patients in chronic renal failure in whom arteriovenous fistula was not constructed as yet.

From July 1, 1966 until February 28, 1970, 64 patients requiring hemodialysis had 775 femoral venipunctures following the Seldinger technique (Table 3). In two patients this technique was employed to perform 16 consecutive dialyses, and in one patient 64 catheterizations were carried out.

Determinations of BUN, creatinine, and serum electrolytes taken predialysis and postdialysis revealed similar values of those obtained in patients with arteriovenous fistulas. The incidence of complications with this technique was extremely low. Hematomas at the site of puncture were recorded in six instances. Infection developed in one patient and phlebitis was noticed in another. Severe scarring after repeated venipunctures was found in two patients. The femoral artery was entered in six instances, was used for the dialysis, but underwent no further complications after catheter removal. In spite of the multiple venipunctures, no patient was restricted from his usual activities after the period of dialysis was completed.

Table 3

EXPERIENCE WITH PERCUTANEOUS TRANSFEMORAL VEIN CATHETERIZATION

July 1966 - February 1970

No. of patients	64
No. of femoral venipunctures:	
For acute dialysis	52
For chronic dialysis	723

Two autogenous vein bypasses in the upper extremities employing saphenous vein grafts were also performed unsuccessfully. A brachial arteryradial vein bypass performed at the Deaconess Hospital worked for a few hours and thrombosed. A brachial artery-cubital artery saphenous vein bypass was constructed at the Lincoln V.A. Hospital and this graft remained patent; however, the flow obtained through the graft was not sufficient for hemodialysis.

Comments: Long term cannulation of arteries and veins was carried out with success since the introduction of the external teflon-silastic prosthesis in 1960.[7] Maintenance hemodialysis and long term survival of patients in chronic renal failure was then possible. However, it became evident that the major cause of dialysis morbidity resulted from the use of this method. Clotting and infections caused frequent shunt failures, and skin erosions, phlebitis, and hemorrhage often made it hazardous. The use of arteriovenous fistulas brought definite advantage over the use of the external teflon-silastic prosthesis, as the complication of internal fistulas is considerably less than those reported by centers using silastic shunts.[2, 3, 4, 5, 8] The major disadvantage of fistulas is venipunctures. In home dialysis programs this procedure is difficult to carry out by patients. On the other hand, shunts will be the method of choice in patients in home dialysis programs and in centers where the specialized personnel is not available. Percutaneous femoral vein catheterizations have proven to be a useful procedure in patients requiring hemodialysis in whom external cannulas or arteriovenous fistulas are not possible.[1, 10, 11] This technique has been employed at the Deaconess Hospital since the establishment of the Dialysis Unit with very low morbidity with postdialysis results comparable to those obtained in patients with arteriovenous fistulas.[1] At the end of the procedure, patients returned to their rooms with no restriction

in their activities and did not experience any significant discomfort related to the venipunctures. Repeated punctures in patients undergoing twice-a-week hemodialysis were performed without difficulties in the insertion of the catheters.

Autogenous saphenous vein bypass graft in the upper arms for hemodialysis was described by Mozes et al[6] with relative success. We performed a brachial artery-radial vein and brachial-cubital artery bypass graft unsuccessfully. We believe this method might be of help to patients in whom fistulas or shunts cannot be created; however, in this situation, the method of percutaneous femoral vein catheterization offers better results in prolonging the life of a patient in chronic hemodialysis.

SUMMARY

Experience with different methods to gain access to the blood stream for acute and chronic hemodialysis is presented. Advantages and disadvantages of each method are discussed. The value of the percutaneous femoral vein catheterization when cannulae or fistulas are not available is also emphasized.

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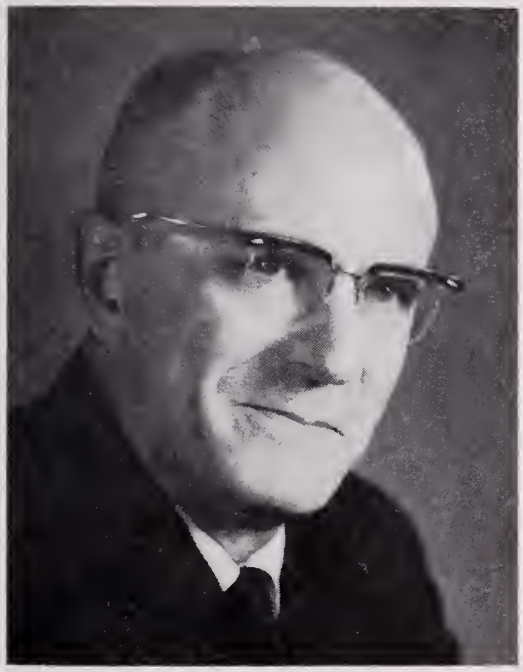
In Memoriam



Dave Powell, 59, died December 5, 1973, in Norfolk, Nebraska, immediately after suffering a heart attack. He was manager of the News Printing Company, publisher of the Nebraska Medical Journal. He had retired only four days before his death.

He was the current President of the Norfolk Chamber of Commerce, Past President of the Norfolk Kiwanis Club, and first President of the Norfolk Junior Chamber of Commerce. He was a member of the city Library Board, of the advisory council to the Small Business Administration, and of the board of the Nebraska Association of Commerce and Industry.

He served on advisory committees to the Northeast Nebraska Technical Community College, was a member of the Nebraska Economic Development Commission, and was a Vice President of Nebraska Diplomats.

He had served as Chairman of the Madison County Polio Drive and on the boards of the Norfolk United Fund and the Norfolk Country Club. He was a member of the Norfolk American Legion and of the Elks Lodge.

He was born in Omaha, attended the University of Nebraska, and served as a captain in the Marine Corps during World War II. He was married to Jeanie Huse in 1936.

He is survived by his wife Jeanie; a son, Dave, San Francisco; a daughter, Mrs. Stephen Gage, Bethesda, Maryland; a brother Clark, San Diego; a sister, Mrs. E. E. Walker, Indialantic, Florida; and two grandchildren.

I met Dave only eight years ago, and our friendship was one of telephone conversations and occasional meetings. He was helpful, ever willing to extend himself, and he was above all a pleasant man. I mourn his passing as I have lost one whose help I valued, whose judgment I trusted, and whose friendship I treasured.

He allowed me to write little marginal notes, and to use words instead of symbols editors are supposed to know.

So I never wrote 30 before, and I cannot bring myself to do it now for Dave, but only to say goodbye to someone I liked, whom I was fortunate to know, and who was willing to be my friend.

F.C.

The Specialist

THE NEUROSURGEON

If surgery is the queen of the medical arts, neurosurgery is the king. Of course, the neurosurgeon frees and transplants nerves and removes disks, along with the orthopedist, but to an admiring lay public, he is a brain surgeon.

This conjures up such adjectives as delicate and wonderful in the minds of his patients, but not in mine, for I have seen him with his brace and bit, and his saw, and I have watched him suck bloody tumors out and say you just can't get it all. But to nondoctors, he is a surgeon of the brain, which is as high as you can get.

When I was a resident, my friend in neurosurgery told me that, while they performed other operations besides craniotomy, the mortality rate of just being admitted to their service was 50 percent, which left me to draw my own conclusions about brain tumors. I am sure that things are better now, but I still have a healthy respect for brain tumors.

I was also told that dying of a brain tumor was not too unpleasant; and that, while the brain is the great nerve center, these patients have little or no pain. I learned, in my own field, that cutting into the brain does not hurt; I mean the patient, I know it doesn't hurt the surgeon.

Frontal lobotomy was popular a few years ago, and was a little on the spectacular and even unlovely side. But the neurosurgeon's operating can be frightfully precise, as when he gets down to the pituitary, or does hemispherectomy. Brain tumors in children were not to my taste; the lesions were bad, and invariably required posterior approach, and you always feel especially sorry for children.

Everybody to his taste, as the French say. I could not think of cutting into people's brains, or even anastomosing nerves; how would I know where all those little fibrils go? But I'm glad we have someone who does know, and who can slash into brains. Only not mine.

I try to stay away from surgeons anyway, and particularly this fellow. But if I ever need him, I'll be glad to know he's there.

—F.C.

Down Memory Lane

1. A shocking percentage of our young men were found physically unfit for military duty.

2. The average doctor is not a bad man.

3. Perhaps our best criterion as to benefit which climate confers is the extreme rarity with which a native Coloradoan develops tuberculosis.

4. A woman's chances of recovery from placenta praevia rest chiefly with the man who sees her first.

5. One of the mysteries of medicine has always been the use of iodine and the iodides.

6. In infancy the almost entire lack of subjective symptoms increases the difficulty of diagnosis in some cases to a considerable degree; but the handicap is somewhat offset by the open fontanel.

7. While trying to relieve the itching and burning of her urethra with a hairpin, she lost the hairpin in her bladder.

8. We are the guardians of the welfare of our great state, for upon the health of its inhabitants depends the prosperity and happiness of its people.

9. The average case with axillary gland involvement, none other being discernible, gives about 10 per cent of cures.

10. The subject, Insulin, is of such outstanding interest to the profession at this time that no apology is needed for offering a succession of papers on the subject.

11. The country has been cursed since the war with a wave of idleness, of economic discontent and of actual crime.

Nebraska State Medical Journal
January, 1924

Coming Meetings

CRIPPLED CHILDREN'S CLINICS—
January 12 — Norfolk, Elks Lodge
February 2 — Scottsbluff, St. Mary's Hospital

SYMPOSIA MEDICA FOUNDATION presents an International Conference on Clinical Problems in Ophthalmology and Otolaryngology to be held in Jerusalem, February 14-24, 1974. For further information, contact: Ms. Cynthia Soika, M.A., Projects Director, Symposia Medica Foundation, 305 East 24th Street, New York, N.Y. 10010.

NEBRASKA MEDICAL ASSOCIATION — Annual Session — April 28 - May 1, 1974, Omaha Hilton Hotel, Omaha, Nebraska.

AMERICAN MEDICAL ASSOCIATION — Annual Session — June 22 - 27, 1974, Chicago, Illinois.

NEBRASKA MEDICAL ASSOCIATION — Fall Session — October 3 - 5, 1974.

AMERICAN MEDICAL ASSOCIATION — 28th Clinical Convention — December 1-4, 1974, Portland, Oregon.

The irritations of man's day are often reflected in his gut.
The causes of irritable colon and the diarrheal symptoms that often accompany it can be as diverse as the systemic and emotional irritations man is faced with daily.
Although the mucoid nature of stools and the occurrence of diarrheal episodes coincident with times of emotional stress may be valuable clues to the functional nature of the disorder, irritable colon must often be diagnosed by exclusion. Such diagnostic exploration takes time. Discovery of the nature of any emotional problems may take more. During that time, Lomotil® is an ideal agent for controlling diarrheal symptoms.
Lomotil tablets are small, easy to carry and easy to take. They act promptly and effectively. Secondary effects are relatively infrequent and, once the first force of the diarrhea is controlled, maintenance is frequently effective on as little as one fourth of the initial dosage.
These same characteristics make Lomotil useful in controlling the diarrhea associated with gastroenteritis, antibiotic therapy and acute infections.

Lomotil®

TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
diphenoxylate hydrochloride . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.

takes care of the gut issue in irritable colon

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

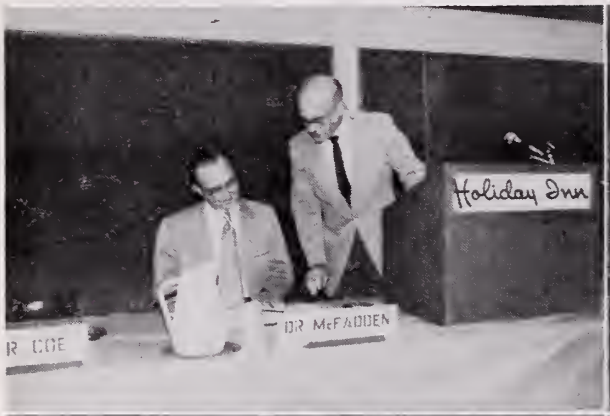
Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

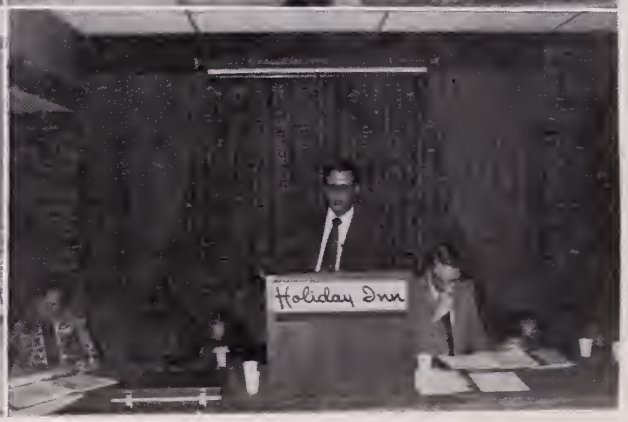
SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries to:
G. D. Searle & Co., Medical Department
Box 5110, Chicago, Illinois 60680

Picture Gallery

FALL SESSION, NEBRASKA MEDICAL ASSOCIATION; KEARNEY, NEBRASKA, OCTOBER 5, 6, 7, 1973.





Holiday Inn

ADAMS

Holiday Inn

Our Medical Schools

New nursing college building at U of N

The University of Nebraska has started a fund drive for a new College of Nursing building.

The goal of $250,000 is necessary to complete funding needed for a five-story building which will be placed on the southeast corner of 42nd Street and Dewey Avenue.

The building is designed to accommodate a student body of 700. It will have three large lecture rooms, classrooms, study areas, research labs, faculty offices and facilities for educational TV, video tape, slide and film presentations.

The United States Public Health Service has provided $2,106,600 toward the structure. The Nebraska Legislature appropriated $1,343,400. To reach the $3,700,000 goal, $250,000 in tax-deductible contributions is needed in private funds.

The College of Nursing's present building was originally intended to provide housing and classrooms for 150 students. Enrollment for the 1973-74 school year is 470. The housing facilities are now crowded classrooms and offices, according to College of Nursing Dean Rena Boyle.

Present facilities inhibit use of new teaching methodologies and small group experiences. The size of an entering freshman class is determined by the size of a 93-seat lecture room, rather than the health care needs of Nebraskans.

The University of Nebraska College of Nursing has made substantial expansion in the last eight years. In 1965 the student body numbered 70, with a graduating class of 18 registered nurses. By 1972 the student body had increased to 426, with a graduating class of 121 registered nurses. Both associate and baccalaureate graduates have consistently ranked above the national average on State Board Licensing Examinations.

Nebraska's nursing program was founded in 1917. At that time the School of Nursing offered a three-year program. In 1950 this program was expanded to a four-year program and offered a baccalaureate degree in nursing. The fully accredited two-year associate degree and a graduate program were added in 1969. In 1971 the School of Nursing was elevated to college status.

WashingtoNotes

Insurance

Two more major national health insurance proposals have been thrown into the Congressional hopper, bringing the total to eight with at least two more waiting in the wings, including that of the Administration.

Chairman Harley O. Staggers (D., W. Va.) of the House Commerce Committee has introduced his own national health insurance proposal (NHI), saying hearings will be held on his bill in the coming year.

The second new NHI proposal came from Senate Republican leader Hugh Scott (R., Pa.) and Charles Percy (R., Ill.).

Staggers' National Comprehensive Health Benefits Act of 1973 would provide comprehensive health care benefits and complete protection against the costs of catastrophic illness to all. It would be financed by a combination of contributions from employers, the federal government and individuals, scaled to income. The federal funds are for health insurance and catastrophic illness benefits for the poor and near-poor.

Major features of the proposal, as described by Staggers:

—a strong role for state governments in the development and administration of the program;

—incentives for the creation and use of Health Maintenance Organizations;

—a six-year transitional period for orderly development;

—the use of existing private health insurance carriers for administration of the insurance provisions;

—and the fact that the program builds on, rather than federalizing, the existing health care system.

The bill provides that newly created State Health Commissions (SHCs) would be responsible for the actual administration of much of the program, including standard setting and quality control, assisting in the development of Health Maintenance Organizations (HMO's) and administration of some of the insurance provisions.

Within two years of enactment all aged, low income and unemployed individuals and families, would be provided coverage for basic health services. Within four years of enactment, all individuals and families would be provided coverage for basic health services and the costs of catastrophic illness. Within seven years of enactment, all individuals and families would be provided coverage for comprehensive health care benefits and the costs of catastrophic illness.

FDA, AMA, HEW, and the public interest

The AMA has asked the Congress to reject proposed legislation that would restrict the Food and Drug Administration's authority over food supplements.

In testimony before the House Commerce Subcommittee on Health and Environment, C. E. Butterworth, Jr., M.D., Chairman of the AMA Council on Foods and Nutrition, said the FDA actions "are based upon sound scientific evidence and are clearly in the public interest."

Under new FDA regulations, U.S. government recommended daily allowances (RDAs) have been established that permit the inclusion of 19 essential vitamins and/or minerals in products to be marketed as dietary supplements.

Ingredients with no recognized nutritional value would be excluded from dietary supplements.

The self-employed

Legislation liberalizing tax treatment of retirement savings by the self-employed seems to be moving closer to congressional enactment in the next session.

The threat of a strict limitation on pension tax deferments in corporations, including professional service corporations, appears to have diminished. The Ways and Means Committee in general accepted the principle in the Senate bill of a $75,000 annual limit on retirement benefit plans (so-called defined benefit plans) and on others (defined contribution plans which included profit-sharing, money purchase, etc.) of a retirement benefit not to exceed 100 percent of the high three years of average compensation.

60s are healthier

President Nixon is correct in his statement that home temperatures in the mid-60s are, in some ways, healthier than temperatures in the mid-70s, according to William Barclay, M.D., Assistant Executive Vice President for Scientific Affairs, AMA.

Emergency medicine

President Nixon has signed into law a three-year, $185 million bill to help set up emergency medical units around the nation.

The bill authorizes grants and contracts for feasibility studies, planning, establishment, operation and expansion of emergency medical systems (EMS) as well as research and training

The bill increases from 50 percent to 75 percent the federal share of grants for

emergency programs and earmarks 20 percent of grants for rural areas.

Radio for emergency medical service

The White House has said that it plans to designate enough radio frequencies for emergency medical service to serve the entire country.

Clay T. Whithead, director of the White House's Office of Telecommunications Policy, says this will be a vital first step in giving American communities the kind of integrated emergency medical services they need to save thousands of lives a year among persons stricken by heart attacks and strokes or injured in accidents. Many such persons now die because they do not get adequate emergency care before they reach a hospital.

Dr. Charles C. Edwards, Assistant Secretary for Health in the Department of Health, Education and Welfare, said the department was putting a high priority on efforts to develop an efficient emergency medical system throughout the United States. How much of the effort should be federal and how much locally initiated is under study, he said.

The Administration plan calls for allocating 38 radio frequencies for emergency medical use throughout the United States. Mr. Whitehead said 22 were already available, but on a much less standardized basis.

Dr. Kindig honored

The American Medical Association has awarded a plaque to David Kindig, M.D., in recognition of his "outstanding and dedicated service in implementing the goals and objectives of the National Health Service Corps (NHSC)."

Dr. Kindig played a key part in launching the NHSC program of sending PHS physicians into physician-shortage areas where help is requested by the local and state medical societies. In receiving the award, the youthful physician said the cooperation of the AMA and of the nation's local and state medical societies has "been" unique and made the program a success."

Between Cases

On Medical Books.

I took down one of my textbooks recently and found a spider had crawled into the book and died. I put the book back; it hadn't helped the spider.

What You Can Do With Statistics.

Half of the doctors graduated in the lower half of their classes.

I graduated in the upper 95 percent of mine.

The Physical.

"Respirations were 20, afrebile."

Words We Can Do Without.

Cognitive, intercom, gut reaction, funding, apropos, overview, ad h o c, plenary, knowledgeable, sophisticated.

English Department.

The lights were turned off in some of the offices, and the explanation was good.

"We're cutting down on ecology."

Maybe Some Day.

One yard penalty for coughing; or one year, whichever comes first.

The History.

"Had a plasty for a hypobladder."

Remember?

Spinal meningitis, lumbago, isometric exercises, sciatica.

The Report.

"Fourth metatarsal of left hand."

Department of Statistics.

About 700 babies are born with birth defects in the U.S. each day.

Very Interesting Diseases (1).

Stripper's asthma, boohoo fever, pink disease, clam-digger's itch.

On Space-Occupying Lesions.

Aren't they all?

I Read It in a Book.

Asystole of 2 to 3 minutes is usually fatal. I know what it means, but if it's fatal, it's not asystole of 2 to 3 minutes.

Very Interesting Disease (2).

There is a pink disease, a blue disease, a a black disease, a White's disease, a rose disease, and a white-spot disease.

—F.C.

Medicinews

Dr. John F. Aita to Omaha

John F. Aita, M.D., will come to Omaha to practice clinical neurology on or about January 1, 1974. Dr. Aita graduated from the University of Nebraska College of Medicine in 1968. Following a rotating internship at the University of Maryland Hospital, he then had three years of residency in neurology at that institution. Subsequently, he has been an associate of Dr. Lowell W. Lapham in neuropathology at the University of Rochester, Rochester, New York.

Home health services

Senators Muskie (D., Me.), and Church (D., Id.), have introduced S. 2690, the Home Health Medicare Amendments of 1973. The bill would end existing Medicare restrictions limiting home health services to nursing care provided by a "skilled" nurse or physical or speech therapy. It would further eliminate the requirement that home health treatment be related to a condition which required previous hospitalization. Full homemaker services would be included under Medicare coverage and allowable home health visits would be increased from 100 to 200. In his introductory remarks, Senator Muskie said that the "skilled" nursing requirement has been a barrier to the provision of needed home care to the elderly, "since it has, in effect, limited the home care benefit primarily to those who are acutely ill and need rehabilitation."

In a related move, Senator Church also introduced S. 2695 which would provide federal funds to aid in the establishment of public and nonprofit home health care agencies in areas without such agencies. Funds would also be provided for the expansion of existing agencies and for grants to public and nonprofit private agencies and institutions for training programs for home health personnel.

Dr. Stafford contributes to new book

"Allergy and immunology in childhood," by Frederick Speer, M.D., and Robert Dockhorn, M.D., was published in 1973 by Charles C. Thomas. The book has 73 contributors, of which G. E. Stafford, M.D., of Lincoln, is one.

Child abuse prevention

The House has passed S. 1191, the Child Abuse Protection and Treatment Act. In passing the measure, the House adopted language reported by the Committee on Education and Labor. The bill would create a National Center on Child Abuse and Neglect and an Advisory Board on Child Abuse and Neglect. Demonstration programs and projects relating to child abuse and neglect would be established and grants would be authorized to assist state governments in developing programs for the prevention and treatment of child abuse. The House-passed ver-

sion authorizes $60 million over three years. The bill will now be returned to the Senate for further consideration.

SCHEDULE OF UPCOMING NCME PROGRAMS

December 31 - January 13

SKYLAB: CLINIC IN ORBIT
With Captain Joseph P. Kerwin, M.D., U.S.N., from NASA Headquarters, Houston, Texas

January 14 - January 27

DRUG SPOTLIGHT PROGRAM: TREATING PULMONARY EMBOLISM

FAILURE TO THRIVE

INFLAMMATORY BOWEL DISEASE: Dx

January 28 - February 10

THE TINGLING HAND

PSRO

INFECTIOUS MONONUCLEOSIS: Dx and Rx

HMOs

The conference report on S. 14, the Health Maintenance Organization and Development Act of 1973, has not yet been released. Although conference agreement on the measure was reached last week, and a report was ordered, the final language is not yet available.

Books

Industrial Mental Health and Employee Counseling; edited by Robert L. Noland; 432 pages; 14½ by 22 cm (5½ by 8¾ in.); hard cover; $16.95; published 1973 by Behavioral Publications, New York.

The author is a Ph.D., an industrial psychologist, and Professor of Psychology at the University of Dayton. The book is all about the problem of mental health and industrial efficiency. There are discussions on counseling and on cooperation by labor, management, and community resources. The text is divided into 5 parts and 34 chapters. I was happy to see William C. Menninger, M.D., as one of the authors.

The print is good. There is no index.

—F.C.

Childhood Learning, Behavior, and the Family; by Louise C. Taichert, M.D.; 112 pages; 14 by 21½ cm (5½ by 8½ in.); hard cover; $7.95; published 1973 by Behavioral Publications, New York.

The book has 8 chapters, a three-part appendix, and an index. The type is not the usual kind, but it is readable. Child and family are thought of as a unit, the child as a growing organism, all of which sounds all right.

There are many references, and many stories of actual children, which is good.

—F.C.

Treatment of Stage I Carcinoma of Cervix— R. C. Park et al (Walter Reed General Hosp, Washington, DC 20012). Obstet Gynecol 41:117-122 (Jan) 1973.

Of 189 patients with clinical stage I carcinoma of the uterine cervix, 156 or 83% of the total series were selected for primary surgical treatment, 150 by radical Wertheim-Taussig hysterectomy. Thirty-two patients received primary radiation. The five-year actuarial survival rate of operated patients is 93%. The corrected five-year actuarial survival rate of the 32 radiated patients is 88%.

Management of Cervical Incompetence — M. S. Robboy (1401 Avocado Ave, Newport Beach, CA 92660). Obstet Gynecol 41: 108-112 (Jan) 1973.

Cervical cerclage procedures were performed on 25 patients. A total of 38 operations of four types were performed on these patients and were followed by 29 live births and nine failures. The cumulated preoperative fetal salvage was 26% of 120 pregnancies. The postoperative salvage rate, including surviving premature deliveries, was 76%. A failure rate of 50% was noted in patients sutured after 20 weeks, compared to 11% in patients sutured before 20 weeks' gestation.

Fibrin Degradation Products in Renal Parenchymal Disease States and Renal Transplant Patients — B. C. Shah et al (Roswell Park Memorial Institute, Buffalo 14203). Transplantation 14:705-710 (Dec) 1972.

Observations on 362 determinations of urinary fibrin degradation products (FDP) and 163 serum FDP in 39 patients are presented. Normal kidney donors had no significant urinary or serum FDP before or after surgical trauma. Patients with advanced glomerulonephritis had significantly higher urinary FDP levels than those with chronic pyelonephritis. In renal allotransplanted patients, urinary FDP levels were significantly higher during rejection episodes.

Esophageal Cancer in California 1942-1969: California Tumor Registry Experience — L. S. Krain (11734 Wilshire Blvd, Los Angeles 90025). J Surg Oncol 5:267-276 (No. 3) 1973.

An analysis of 3,319 cases of esophageal cancer from the California Tumor Registry, 1942 to 1969, showed that esophageal cancer predominates in the Negro race, in urban areas in California, and in the lower socioeconomic classes. Esophageal cancer occurs at a medial age of 63.8 years and has a male/female sex ratio of 2.84:1. Despite an increase in the percentage of cases localized at the time of diagnosis, the five-year survival (localized cases) for patients with esophageal cancer has remained constant at 7%. The mean survival from the time of diagnosis for all stages of the disease was 5.2 months. Although there has been a slight increase in incidence of esophageal cancer, the mortality has remained constant at 2.4/100,000 (age-adjusted).

Otolaryngological Manifestations of Tularemia — I. W. S. Mair et al (Sentralsykehuset, Tromso, Norway). Arch Otolaryngol 98:156-158 (Sept) 1973.

During a two-year period a total of 11 patients was seen with oropharyngeal and cervical tularemia. Diagnosis was established by biopsy and the demonstration of rising titers of tularemia antibodies. It is probable that tularemia is a more frequent cause of infection in the head and neck than a review of the literature would indicate.

Erythrocyte Deformation As Sign of Renal Homograft Rejection — A. K. Guevarra et al (Hutzel Hosp, 432 E Hancock, Detroit 48201). Transplantation 14:683-688 (Dec) 1972.

Eight patients rejected 11 renal homografts and one of the consistent signs observed during the rejection period was the appearance of an abnormal number of schistocytes in the peripheral blood. Supporting evidence suggests that vascular damage in the graft secondary to immunological injury was the causative factor.

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Physicians' Classified

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CLINIC AVAILABLE — General practice in furnished clinic. County seat town, SW Nebraska. Three nursing homes in town, good territory. Equipped office available for dentist. Write Box 8, Beaver City, Nebraska 68926.

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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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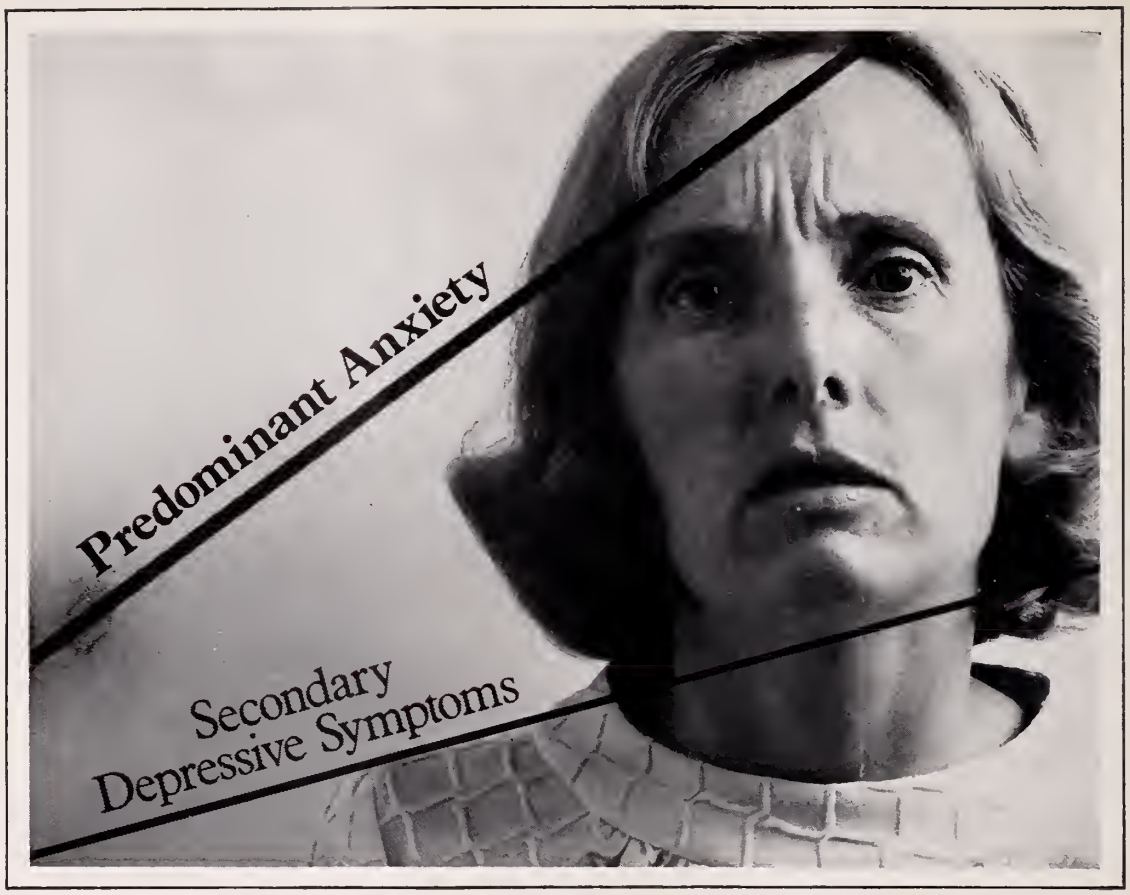

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The Nebraska Medical Journal

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Human Growth Hormone Secretion After Double Stimulation With Arginine in Normal and Insulin - Dependent Diabetic Women — L. Koncz et al (170 Pilgrim Rd, Boston 02215). Diabetes 22:694-705 (Sept) 1973.

Growth hormone (GH) secretion was studied with a modified arginine test, infusing two doses 80 minutes apart, in normal and juvenile onset diabetic women. Diabetics differed from normals in several qualitative aspects of GH secretion. Biphasic response to the two stimuli was lost in diabetics. Baseline GH levels in normals showed a significant negative correlation with GH response after the second stimulus in normals and in short duration, but not in long duration, diabetics. Fasting blood glucose levels correlated positively with baseline GH values and the first GH peak in normals but not in diabetics. Only the normals showed positive correlation between the amount of arginine per kilogram body weight and GH response. Sensitivity to stimulators of GH release in diabetics may be impaired or the GH release mechanism may be defective. Diabetics with retinopathy showed blunted GH response.

Stenoses and Occlusions of Carotid Artery H. Keller et al (Kantonsspital, Zurich, Switzerland). Dtsch Med Wochenschr 98: 1691-1698 (Sept 14) 1973.

By using Doppler ultrasound techniques over the supraorbital or supratrochlear arteries, stenosis of the internal carotid artery between bifurcation and origin of the ophthalmic artery can be diagnosed. The technique was used in 162 patients. Subsequently, carotid angiograms were performed in 110 patients which confirmed eight cases of occlusion diagnosed by the Doppler technique and 47 of 55 stenoses of varying degrees. In some of the 12 false-positive cases degenerative changes in kinking and orbital trauma were present. In the remaining 35 patients there was no evidence of stenosis of the internal carotid proximal to the origin of the ophthalmic artery.

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Reevaluating Use of Lidocaine — M. A. Nevins (Bergen Pines County Hosp, Paramus, NJ 07652). Geriatrics 28:48-51 (Aug) 1973

Major side effects of lidocaine are primarily those of central nervous system toxicity and include somnolence, irritability, euphoria, paresthesia, twitching, and convulsions. Lidocaine has been ineffective in terminating ventricular tachycardia in the presence of hypokalemia. Certain ventricular arrhythmias may be refractory to lidocaine or possibly potentiated by it. Rate acceleration with atropine should be attempted first when there is an associated bradyarrhythmia, and pacemaker overdriving should be considered for refractory ventricular tachyarrhythmias. Any hypokalemia should be corrected. When reentry is a basic mechanism of short coupled ectopics, lidocaine may be an aggravating factor particularly when low blood levels are present. Procainamide and propranolol might be more suitable agents for controlling these dangerous arrhythmias.

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References: 1. Koch-Weser, J., and Sellers, E.M.: New Eng. J. Med. *285*:447-458 (Sept. 2) 1971. **2.** Udall, J.A.: Clin. Med. *77*:20-25 (Aug.) 1970. **3.** Mielke, C.H., Jr., and Britten, A.F.H.: New Eng. J. Med. *282*:1270 (May 28) 1970 (corresp.).

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Illustrations should be numbered and their locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be in black (India ink) on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

Manuscripts (original, not a carbon) should be sent directly to the Editor at the **Journal's** address.

Letters to the Editor submitted for publication should be prepared as above, and must carry the notation: To be Published.

Reprints should be ordered from the printer, Norfolk Printing Co., Inc., P. O. Box 278, Norfolk, Nebr. 68701.

Personality Disorder and Reactive Hypoglycemia — D. Anthony et al (Metabolic Research Unit, Univ of California, San Francisco 94122). Diabetes 22:664-675 (Sept) 1973.

Thirty-seven patients were evaluated for reactive hypoglycemia according to blood glucose nadir and plasma cortisol response to the nadir. The Minnesota Multiphasic Personality Inventory was given to these patients and to 21 patients with various non-hypoglycemic endocrine disorders. Definite, probable and possible hypoglycemic patients obtained a "conversion V" pattern two standard deviations above normal on this test. Their scores differed significantly from those of patients with mixed endocrine disorders ($P<0.001$) and vaguely symptomatic patients ($P<0.05$). The latter groups had scores within normal limits. Patients with hypoglycemia of differing etiology show the same "conversion V" personality pattern. Hypoglycemia may be a cause of personality disorder.

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Intrapartum Fetal Monitoring — W. H. Chan et al (12012 Compton Ave, Los Angeles 90059). Obstet Gynecol 41:7-13 (Jan) 1973.

One thousand one hundred-fifty labors were monitored. Postpartum febrile morbidity could not be attributed to the direct techniques used for intrapartum monitoring. Three asymptomatic uterine perforations were encountered with the transcervical intrauterine catheter. There were no complications from these perforations. Scalp abscess and major fetal morbidity due to the application of the electrode were not seen in this study. There were two intrapartum stillbirths among the monitored labors.

Pattern of Malformation in Offspring of Chronic Alcoholic Mothers — K. L. Jones et al (Univ of Washington School of Medicine, Seattle 98195). Lancet 1:1267-1271 (June 9) 1973.

Eight unrelated children of three different ethnic groups, all born to mothers who were chronic alcoholics, have a similar pattern of craniofacial, limb, and cardiovascular defects associated with prenatal-onset growth deficiency and development delay.

Vasoactive Intestinal Peptide and Watery-Diarrhea Syndrome — S. R. Bloom et al (Institute of Clinical Research, Middlesex Hosp, London). Lancet 2:14-16 (July 7) 1973.

Six patients with the watery-diarrhea syndrome (pancreatic cholera) were found to have raised plasma levels or high tumor content of vasoactive intestinal peptide (VIP), or both, as measured by a specific radioimmunoassay. Positive immunofluorescense with VIP antisera was obtained in two patients in whom properly fixed tumor material was available. The known actions of VIP accord well with the abnormalities found in the watery-diarrhea syndrome. The availability of a plasma-VIP assay may enable the diagnosis to be made before tumor metastasis occurs.

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Management of Patients With Radiation-Induced Pericarditis With Effusion: Note on Development of Aortic Regurgitation in Two of Them — D. L. Morton et al (D. L. Glancy, 1542 Tulane Ave, New Orleans 70112). Chest 64:291-297 (Sept) 1973.

Pericardial injury is the most serious cardiac consequence of radiation therapy, and it often leads to chronic pericardial effusion and not infrequently to cardiac tamponade. Removal of the damaged parietal pericardium by subtotal pericardiectomy effectively relieves the cardiac tamponade and probably prevents the subsequent development of constrictive pericarditis. Of 17 patients whose radiation-induced pericardial effusions were treated by subtotal pericardiectomy, 12 are living and well without evidence of any great cardiac dysfunction up to three years after operation. Pericardiectomy may be indicated even in patients with recurrent Hodgkin disease, since further radiation or chemotherapy may provide long-term paliation.

Death From Thyrotoxicosis—J. L. W. Parker (Dept of Medicine, Western Infirmary, Glasgow, Scotland) and D. H. Lawson. Lancet 2:894-895 (Oct 20) 1973.

In a series of 33 patients dying primarily from thyrotoxicosis, over half of the deaths occurred during the first two weeks in hospital and almost half of the patients were under 60 years. Factors which indicated a poor prognosis included tachycardia (>120 beats/minute), atrial fibrillation, congestive heart failure, and thyroid crisis; however, some 15% of these patients died suddenly and unexpectedly in the absence of demonstrable myocardial infarction or pulmonary embolism. Eighteen percent had major embolism and this has not previously been stressed as a cause of death in thyrotoxicosis. Over 21% of the deaths occurred within three weeks of radioactive iodine therapy. Patients with pronounced thyrotoxicosis should have antithyroid drugs before and after ^{131}I therapy.

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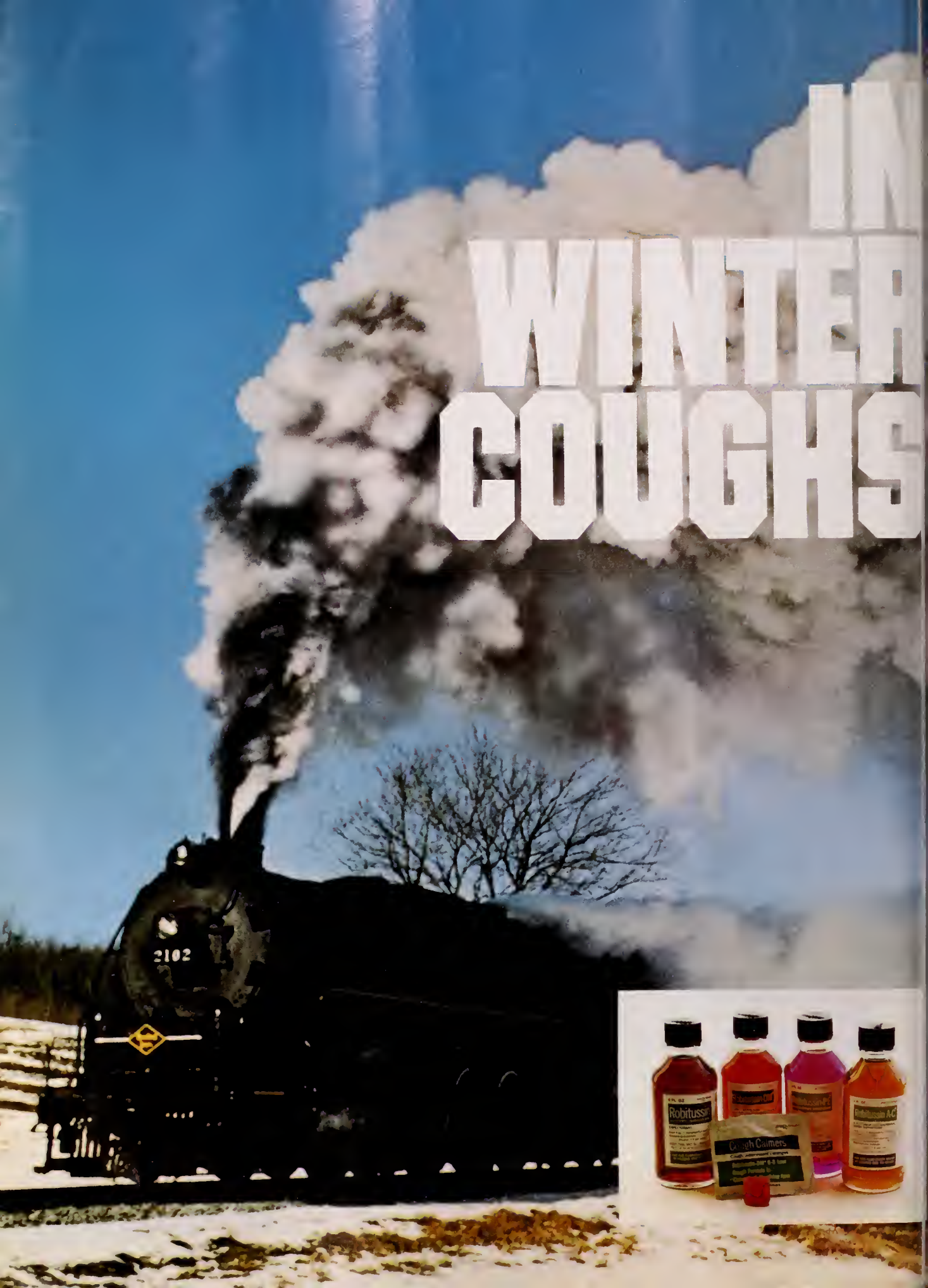
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The Weight of Professional Opinion

It's time for action to defend the laws and regulations that protect your patients against drug substitution.

These professional and trade organizations are united in supporting antisubstitution statutes and regulations:

The American Academy of Dermatology

The Board of Directors of the American Academy of Family Physicians

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The Committee on Drugs of the American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the American College of Obstetricians and Gynecologists

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The American Psychiatric Association

The Executive Committee of the National Association of Retail Druggists

The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association

Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is o affirm the support of the participat- ng organizations for the laws, regula- ions and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, den- ists and pharmacists have worked cooperatively to serve the best inter- ests of patients. Productive coopera- ion has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been eflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, den- al and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of them- selves guaranteed absolute protec- ion from unsafe drugs, or freed physicians, dentists and pharmacists rom their responsibilities to patients. As a practical matter, however, such aws and regulations encourage inter- professional communications regard- ng drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be im- proved through such communica- tion, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physi- cians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selec- tion remain primary and do not per- mit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved under- standing and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthor- ized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

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What's on your patient's face...

may be more important than his chief complaint

Patient P.T.* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.

Patient P.T.* seen on 6/12/67, seven weeks after discontinuation of 5% FU cream. Reaction has subsided. Residual scarring not seen except that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.
*Data on file, Hoffmann-La Roche Inc., Nutley, N.J

The lesions on his face are solar/actinic— so-called "senile" keratoses... and they may be premalignant.

Solar, actinic or senile keratoses

These lesions may be called by several names, but they usually can be identified by the following characteristics. The typical lesion is flat or slightly elevated, of a brownish or reddish color, papular, dry, rough, adherent and sharply defined. They commonly occur as multiple lesions, chiefly on the exposed portions of the skin.

Sequence of therapy— selectivity of response

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Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

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Neuropsychologic Effects of Continuous Oxygen Therapy in Chronic Obstructive Pulmonary Disease — H. D. Krop et al (A. J. Block, VA Hosp, Gainesville, FL 32601). Chest 64:317-322 (Sept) 1973.

Continuous ambulatory oxygen therapy was administered at 2 liters/min by nasal cannula to a study group of ten hypoxemic patients with chronic obstructive pulmonary disease (COPD). A battery of neuropsychologic and psychologic tests was administered and later repeated. The results were compared to similar testing performed in a less severely hypoxemic comparison group of 12 patients with an equal degree of COPD. The hypoxemic treatment group initially scored much lower than the comparison group in five neuropsychologic tests. With oxygen therapy great improvement occurred in eight of ten neuropsychologic test results, and in four psychologic test results. No improvement was noted in the comparison group. After oxygen therapy the previously noted differences between the treatment and comparison groups were no longer evident. These data suggest that hypoxemia is associated with depression in neuropsychologic and psychologic functioning.

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Hepatitis-B Antigen in Colony Mosquitoes — D. Metselaar et al (Medical Research Center, Dept of the Royal Tropical Institute of Amsterdam, PO Box 49370, Nairobi, Kenya). Lancet 2:758-760 (Oct 6) 1973.

Aedes aegypti mosquitoes were fed on or inoculated with blood or serum positive for hepatitis-B antigen (HBAg) or allowed to feed on the arm of an HBAg carrier. Pools of mosquitoes were tested by radioimmunoassay at intervals up to 45 days after exposure to HBAg. The findings suggest persistence (but not necessarily replication) of HBAg in mosquitoes.

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HL-A Antigen Type and Small-Intestinal Disease in Dermatitis Herpetiformis — R. L. Gebhard et al (S. I. Katz, Dept of Pathology, Royal College of Surgeons of England, London). Lancet 2:760-762 (Oct 6) 1973.

Of 28 patients with dermatitis herpetiformis, 68% had leukocyte antigen HL-A8 compared with a frequency of 17% to 30% among normal population groups. Eighty-four percent of patients with associated villous atrophy (determined by small intestinal biopsy) carried HL-A8, whereas only 33% of patients without gastrointestinal disease had HL-A8. Eighty-four percent is similar to the frequency previously found for glutensensitive enteropathy (celiac disease).

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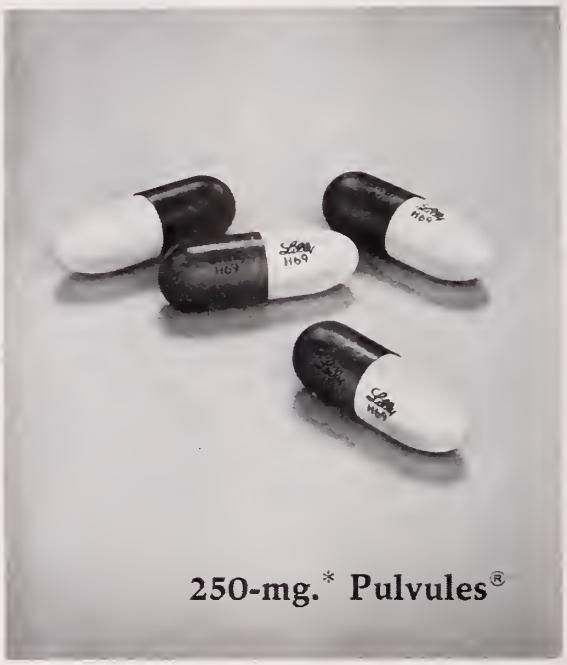

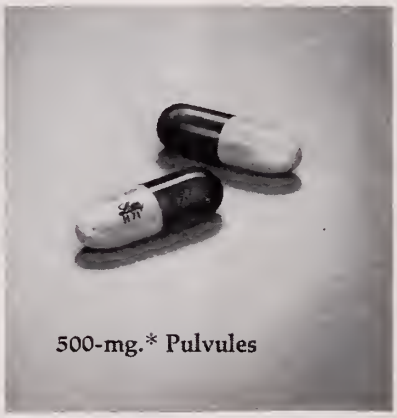

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THE NEBRASKA MEDICAL JOURNAL

THE HEALING PROCESS

Nobody lives forever, and in the end, all our patients die; and in the end *we* become patients and we die, too. What then is the role of medicine? Not to keep people alive forever, only a little longer; and recently we have stopped trying to prolong lives when death is imminent, and when further living is painful and pointless.

When a bone is broken, it seems foolish not to bring the ends together and let it heal. When there is pain, it is only sensible to abolish it. Where there is bleeding, no amount of philosophizing can keep us from applying a tourniquet or from securing the bleeding vessel.

For there is the healing process, which mirrors our own feeble attempts to cure people. And is not the healing process an unsuccessful attempt to achieve immortality? I can understand that our bodies are, however wonderfully constructed, uniformly imperfect, and that they wear out and so we die, every one of us, like the wonderful one-hoss shay. But in the face of the refusal of the powers that be to let us live forever, why do we heal?

We do not grow new extremities, or shed and reform whole skins, or do any of these things the lower animals do. But we heal. Bones can be counted on to unite, skin heals, mucous membrane heals, muscles grow together and so do tendons and even nerves sometimes. The spinal cord won't do it, but someone is supposed to have grown a third femur.

Each instance of the healing process is like a little step backward in time, toward birth, and away from inevitable death. It is strange, it cannot possibly succeed, it is something to wonder at, and it is poorly understood, but there it is.

—F.C.

THE IMPOSTOR

Now and then, someone who has been practicing medicine is shown to be an impostor. He pretends to have graduated from medical school and to be the rightful owner of all sorts of diplomas. He has often assumed a name that is not his, and has displayed certificates and licenses that have belonged to others. He is not a physician, and so he is then properly enjoined from practicing medicine and from treating people.

I understand neither what prompts individuals to become charlatans nor the failure of the communities and the authorities involved to investigate properly, so that impostors would never go into business.

But what I appreciate least of all is the unvarying reaction of the communities and of the pretender's patients. For people seem without exception to flock to his defense. They do not care that he is completely unqualified and that it is dangerous to allow him to continue. It is of course also illegal; the opposition comes from the law courts rather than from bona fide medical practitioners, and has nothing to do with jealousy or with fear of competition.

For patients come in droves to testify to his defense; they tell everybody who will listen of his skill and of his many successes. My answer is that they have been lucky, I advise them not to press their luck, and I marvel at their foolishness.

—F.C.

BRING BACK THE RESPIRATORY RATE

When a dyspneic patient is sent for a special respiratory examination, the report is often preceded by a series of numbers or even consists of a mass of laboratory reports. At the beginning, we are given the patient's age and height, sometimes the weight, then the blood pressure and pulse rate; and if we are lucky, the hemoglobin.

From the laboratory we get total lung capacity, forced expiratory volume, and residual volume; as well as inspiratory capacity, ventilation index, reserve air, maxi-

mum breathing capacity, and many others. Again, if we are lucky, there may be a tidal volume, and I am all for FEV_1 and for VC.

But in between the little items checked in the doctor's office and the technical things reported by the lab, there is one important number that is almost never found on the report.

How fast was the patient breathing?

The respiratory rate has gone out of style; it is rarely measured.

Breaths are easy to count; you don't even need to touch the patient.

Bring back the respiratory rate.

—F.C.

THE DEMISE OF PROFESSIONAL COURTESY

Doctors didn't usually charge doctors, and that was a wonderful custom. There would be thank-you handshakes, and at Christmas, cards and gifts. But the thanks were enough; nothing more was really expected. We simply didn't send bills to each other, and it was one of the traditions of our profession.

I know we were allowed to charge other physicians, and it was done, but there were so many times when we donated our time and services without thought of recompense. Sometimes you would treat a colleague's wife, and later he would take care of you, and you were even.

But the custom is disappearing, and it is sad.

For now we have Medicare; and many of us own medical insurance, which we buy for hospitalization, but which includes payments for doctors' bills. And we say to the doctor who doctors us, I want you to take it, that's what I have it for. And as the custom of not charging is leaving us, so too is the reluctance to accept payment from an insurance company.

There is no free lunch; money does not come from nowhere. Insurance is paid for one way or another.

I have heard doctors' wives say they wished they were not courtesy patients, so they could be treated as paying clients; they might ask more questions and not expect cursory answers. It would somehow be more businesslike, and yet as personal as before.

Hello, Blue Cross; hello, Blue Shield; hello, Medicare.

Goodbye, courtesy.

—F.C.

TWICE A DAY OR ONCE A YEAR

Take one capsule every hour, we say, or come back every year. We live by days, or light and dark sequences; and we age by seasons, or years. Three times a day or every four hours may not be quite right, but it is better than getting up at night to take a cough mixture or a sleeping powder. Should a woman have a test twice a year, and ought one to get a chest roentgenogram every Thanksgiving and a proctoscopy on New Year's Day?

Those who have gone into caves have come up with 28-hour days, and in flying, we lose our circadian sense. A physical checkup is advisable from time to time, but these periods are determined by medical factors, and examinations may best be had at nine or at 13 month intervals.

Common sense and being practical enters into much of this, and so I change my watch energy cell on my birthday, if I can remember it. But twice a day and once a year may not be the way to prescribe. I once tried shaving one morning and the next evening, but it didn't work. Homeopaths had you taking medicine something like every hour.

Have a cervical smear every seven months, we might say, or take a chest x-ray at 40-week intervals, or swallow a coffeespoonful of this goodie every 200 minutes.

But take the pill every day.

—F.C.

FULL OF SOUND AND FURY, SIGNIFYING NOTHING

There are medical words I should like to banish to obloquy, because they have little or no meaning, and because using them blocks communication. Arthrotomy means an operation on a joint, often the knee. It may indicate that nothing was found, that a foreign or a loose body was removed, that a cartilage was taken out, that the patella went the way of orthopedic surgery, or that things were transplanted.

Cardiac arrest means that the heart has stopped. It is an elegant phrase without meaning. Hearts stop as a result of too little oxygen, too much anesthetic, respiratory obstruction, blood loss, or coronary occlusion. There is no strange and unidentified agent that flies through closed operating room windows and strikes without warning.

Celiotomy means an incision into the abdominal cavity. But the appendix may have been removed, lysis of adhesions performed, incurable cancer discovered, or no pathology found. Laminectomy means an operation on the back, and excision of the posterior arch of a vertebra. But was the spine fused, did the surgeon take out a disk, was there a tumor, or was nothing found?

An inoperable tumor is a tumor you are operating on; unresectable is a better word.

Laparotomy is even worse than celiotomy, because it is used oftener. Thoracotomy means an incision of the chest wall, and usually implies that an operation was performed somewhere in the chest. But it does not tell us if the heart was repaired, if a lung was removed, if cancer was found, or if the exploration was negative.

There are two cervicals, but this word means something. Palsy is something of a weasel word, because the reader does not know what the writer means. Arthrotomy, cardiac arrest, inoperable, celiotomy, laparotomy, and laminectomy are words that should be laid to rest; they are cop-outs.

It is better to say gastrectomy, spinal fusion, pneumonectomy, meniscectomy, diskectomy, and anoxia.

—F.C.

Determination of Amputation Level: Measurement of Skin Blood Flow With Xenon 133 — W. S. Moore (VA Hosp, San Francisco 94121). Arch Surg 107:798 - 802 (Nov) 1973.

In 31 patients about to undergo 33 below-knee amputations, skin blood flow adjacent to the anterior line of the incision was measured by Xe 133 clearance in an attempt to correlate success of healing with the quantity of skin blood flow. Three amputations failed to heal because of ischemic necrosis. These three amputations had the three lowest blood flows, indicating that the use of skin blood flow is a promising method for preoperative selection of amputation level. A comparison of skin blood flows with the level of distal palpable pulse and angiographic data of the peripheral circulation showed no correlation, confirming that these measures for estimation of qualitative blood flow should not be used in selection of the amputation level.

Systemic Lupus Erythematosus: Studies of Antibodies Bound to Skin — M. Landry (Mayo Clinic and Mayo Foundation, Rochester, MN 55901) and W. M. Sams, Jr., J Clin Invest 52:1871-1880 (Aug) 1973.

Systemic lupus erythematosus (SLE) is characterized by antibodies demonstrable by immunofluorescence on renal glomeruli and at the basement membrane area of both normal and involved skin. Acid eluates from glomeruli and from normal-appearing skin of three patients with SLE contained an antinuclear antibody.

Occult Primary Tumor — L. K. Winegar (Toledo Clinic, Toledo, OH 43623) and W. Griffin. Arch Otolaryngol 98:159 - 163 (Sept) 1973.

Patients having metastatic cervical malignancy with an unknown primary source are termed occult primary patients. From 1953 to 1969, 106 occult primary patients were treated at the University of Michigan. These cases are reviewed with the conclusion that surgery is the best initial management in most patients.

The Need for Pre-Abortion Counseling — Now More Than Ever

NORMAN D. WEST, M.D.
and
MARGARET A. WALSH
Nebraska Psychiatric Institute
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ON January 22, 1973 the United States Supreme Court mitigated the abortion laws of the majority of the States. The stipulation that the pregnancy must pose a threat to the mental or physical health of the woman was ruled unconstitutional thereby opening the door to abortion on request.

When the freedom of choice lies in the area of continuing a pregnancy (or terminating it) — the advisability of proper counseling should be seriously considered.

As a result of the Court decision the only requirements for obtaining an abortion are a request and the funds. The legality or illegality of the issue has never considered the possible threat abortion may pose to a woman's mental health.[7] Prior laws generally have specified that abortion could be performed only if the pregnancy posed a threat to the physical or mental health of the woman. Preabortion counseling previously done has elicited conflicts within the woman which may be signaling danger.

Counseling by competent, trained, unbiased professionals should remain an integral part of the preabortion requirements. Before the Supreme Court decision, a psychiatric opinion was required on a candidate for abortion in most states.[1] This was to establish the risk to the woman's mental health the continuation of pregnancy posed. Paradoxically, many of these screenings brought out the unresolved conflicts within the woman[2] in regard to terminating the pregnancy and that, in reality, her mental health would be endangered by the abortion.

A questionnaire designed by the psychiatrists, which the woman completed before her interview with the psychiatrist, consistently showed that many women were, at best, unsure about abortion; in fact, many did not want it at all.

Completing the questionnaire frequently disclosed the first suggestion of an inner conflict in the woman seeking to terminate her pregnancy. Some of the questions that gave insight into possible conflicts were: Do you have any religious conflicts about abortion? Are there any unresolved doubts about abortion? Are there any conflicts with parents or relatives about abortion? Have you had counseling regarding abortion? If the abortion is granted, would you be interested in follow-up therapy?[6] The last question often provoked the girl's first insight into how she regarded the pregnancy she was seeking to terminate.

Frequently the dilemma that encompasses a pregnant woman, be it social or economic,[4, 5] compels her to regard termination of the pregnancy as the only resolution of the problem because of the outside pressures involved. Counseling at this point could be extremely beneficial — it could open the door to the inner feelings of the woman which the anxiety of the situation has obliterated. The counselor could offer an objective view and the emotional stability required to weigh the important factors involved in the final decision regarding the pregnancy. Exploring the alternatives to abortion and discussing their feasibility with the girl could do a great deal to uncover suppressed feelings.

Initially, a request for an abortion is presented as a desire to have an unwanted, unplanned or undesirable pregnancy terminated. The motivation for the request should be examined: does the woman herself want the abortion, or is she being coerced by her family or social pressure?

Religious background can have a deleteri-

ous effect on a woman if not given proper consideration. Many religions have very absolute teachings regarding an unborn child. Under emotional stress and an elevated anxiety level, the woman may feel she will either experience no guilt feelings, or that she will be able to handle them satisfactorily. Strong religious beliefs that are not given adequate deliberation can be extremely damaging.

The attitude of an unwed girl's family or close friends in regard to the pregnancy often is a powerful influence in an abortion request. Frequently the girl's negative attitude is a strong reflection of a mother who is determined that the pregnancy must be terminated — or a fear of informing a tyrannical father of her condition. These pressures allow little or no possibility for the girl to consider her own feelings.

Out of one group of girls who were referred to a psychiatrist for screening for possible abortion, several were found to have serious unresolved conflicts about pregnancy and abortion. The new concept promulgated by the Court ruling considers only the decision of the woman as regards the physical aspects of the pregnancy. Three case histories are presented to illustrate how preabortion screening brought out the fact that the woman can have inner conflicts that she has suppressed.

Case 1: A 17 year old, divorced woman, sixteen weeks pregnant, sought an abortion because she could see no way she could carry the pregnancy to term nor support the child afterward. The patient was, herself, the product of an unwanted pregnancy, and had been given up by her mother at six months of age. She was reared by her grandmother, who died while the patient was hospitalized as the result of an automobile accident in which her fiance had been killed. Shortly after she was released from the hospital her God-child, to whom she was very close, died of crib pneumonia. She stated she had always wanted a baby and had already fallen in love with the child she was carrying. Mention was made to her that there were alternatives for her to consider, e.g. residence in a home for pregnant girls or a board and room work agreement in a private home and after delivery, employment for her to support the child. She was extremely interested in these possibilities, and during the course of her interview with the psychiatrist asked his assistance in getting admitted to a home for pregnant girls. About two weeks after the initial interview the patient called the psychiatrist and told him she wanted to carry her pregnancy to term.

Case 2: A 16 year old, unmarried girl with an eleven month old daughter stated that when she delivered her first child she had to remain in the hospital for about two weeks because of the possibility of a heart problem. She was apprehensive that a second delivery would create a similar problem. An appointment was scheduled for an abortion screening. She appeared two and a half hours late for the appointment, offering no excuse for being late. Another appointment was scheduled for her later in the week, and she was one and a half hours late for the second appointment and the psychiatrist could not see her. This was reported to the OB Clinic and her doctor was advised that no further appointments would be made for her. Her caseworker interceded and a third appointment time was granted. She was 45 minutes late for this appointment and the psychiatrist refused to see her. Another psychiatrist did, however, agree to see her and recommended an abortion. The abortion was approved at the hospital and a date and time was scheduled for the abortion. She did not appear for the abortion.

Case 3: A 30 year old married woman, mother of four, appeared for her appointment for abortion screening carrying her youngest child (11 months of age) in her arms. The child was a very well-cared for, obviously loved, happy child. Completing the application brought out the fact that another child would work a hardship on the

family financially, but also brought out the fact that the pregnancy per se was creating no problems for the woman. By admission, the pregnancy had not caused anxiety, fear, nervousness, unclear thinking or any other symptoms to pose a threat to her mental health. When questioned as to alternatives if abortion was refused, she answered that she would bear the baby and love it. Since no psychiatric indication for abortion was elicited, it could not be recommended. The woman is being followed by the psychiatrist for supportive therapy while she is awaiting the birth of the baby.

Great care has been exercised to protect the *civil rights* of the woman seeking an abortion. Shouldn't equal care be exercised to protect the mental health of this same woman?[9]

Counseling could help determine the girl's attitude toward the pregnancy. The anxiety attendant upon being pregnant makes it difficult for the girl to sort out her real feelings. An effort should be made to assess the inner conflicts of the girl; is termination of the pregnancy the solution or does she have unresolved doubts about abortion?[3] What alternative could there be? Is there a workable plan for continuation of the pregnancy and rearing of the child? These are considerations that should be pursued for the benefit of the woman.

No conclusive, long-term studies[8] have been conducted on control groups who carried their pregnancies to term and those who were therapeutically aborted to prove or disprove the psychological impact of abortion on a woman. Until this is done it cannot be said that abortion does not disturb the psyche.

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Dear M.D.'s Wife: Who, What and Where Are YOU?*

EUNICE ROLLER
North Central Vice-President
Woman's Auxiliary to the A.M.A.

YOU are repeatedly told you are a woman married to a doctor and a valuable member of the community where you live. Do you also feel you are at an 'Interface' which can be called a place of Blending-of-the-Boundaries, a common ground holding together opposing forces? What do we mean by that? Let us first look at the diamond cutter who holds a piece of native crystalized carbon in his hand, and he forms in his mind a mental picture of a future precious gem. He looks closely at the 'interfaces' where the crystals meet so that by study and careful carving his goal may be accomplished . . . that of a diamond beautifully cut and not a stone shattered by force. Next, let us look at the sculptor who wants to create an art work of beauty. He accepts the reality of the necessity to direct his chisel along the interfaces of stone if he is carving his design. Human relationships, like stones, also have interfaces and the world we carve depends upon our development of the skills necessary for the desired results. With careful cooperation the ever-present interfaces can make possible the changes necessary for the building of a life-of-beauty for all people. We also realize that by exerting too much pressure on the boundary lines that we call interfaces we can cause disaster.

Yes, in our world the interfaces are there . . . between the generations, the classes of society, the races, the different levels and kinds of education, the patterns of access to health care, etc. And if the pressures mount too high we have frustration, conflict, suffering . . . the experiences we call painful that in time demand relief. Because your life is related to "medicine and health" you may feel the increased demands upon you by the community to help create a life of quality for "wilthout health . . . there is no quality of living." And you may appreciate some guidelines in making your choices to help. Perhaps you should ask yourself questions such as "what kind of world do I hold in my hand, in my mind what do I envision for the future, what values claim my heart and support, what is my mission in life?"

The Auxiliary can help you find a place where you, the member, are needed . . . a place that will inspire you because it will have a purpose and you will find meaning and a sense of fulfillment in it. Our medically oriented community offers freedom of choice in a wide-range of study and action areas . . . all geared to improving the present and planning for the future. And important too, it provides friendship, fellowship, and fun!

And one writer wrote it well, "The world these days is not shaped by heroic leaders straining for greatness. As rarely before it is in the hands of ordinary men, cutting down to manageable size the larger-than-life pretensions inherited from lofty predecessors. That is what progress is all about." It boils down to what you and I do where we are! When you put it all together the list of our efforts and accomplishments is an impressive one. To mention a few: this past year we raised $740,388.00 for AMA-ERF, bringing the total to over five million dollars since 1951 when the Foundation was started. For Health Manpower Scholarships and Loans $654,889.00 was raised. This brought our total contributions of combined state and county auxiliaries to $1,395,278.00 for 1972. In addition to the many activities in the Legislative Field, we have a new kit of Resource and Leadership Materials. International

*Presented at the 48th Annual Meeting of the Woman's Auxiliary to the Nebraska Medical Association April 30, May 1, 2, 1973.

Health Activities continues to be one of the most popular service areas.

Dr. John Kernodle, Chairman of the AMA Board of Trustees, has encouraged the Auxiliary to promote Health Education in the schools, and to help the American people understand that Health Education informs the individual in what he can do for himself in illness prevention and health maintenance. The Health Education and Health Service Committees provide guidance and resource materials in areas of greatest concern as: Nutrition with a new Package Program that provides information for every age and income bracket; Safety with an emphasis on Safety on the Streets and Highway Safety; Children and Youth with special attention to Venereal Disease; Mental Health including Drug Abuse; Aging and Homebound, Blood Donors; Day Care Centers, Ecology and others. The County Auxiliary is encouraged to survey the community it serves and choose the programs most needed.

Membership continues to be of primary interest. Dr. Kernodle included in his challenges to the Auxiliary the challenge to promote strength and unity in the Medical Profession. Auxiliary members can assist the AMA's Membership Campaign by suggesting to the wives of nonmembers that they encourage their husbands to become AMA members. AMA membership is a privilege that is earned and respected. Auxiliaries on the national, state, and county levels first seek the guidance and leadership of their respective Medical Societies before undertaking a program or a project. As always, the Auxiliary recognizes the value and seeks every opportunity to encourage good relations among physicians' families. Social events play an important part in the year's calendar . . . they provide a climate of friendliness, fellowship and understanding. Joint or simultaneous meetings of doctors and wives are highly recommended when feasible.

Membership is always a high priority and the National Auxiliary has some excellent materials which include "Blue prints for Building Membership" for both the state and county auxiliary. Answers to many of your questions can be found in the "Blueprints" so keep a copy at your fingertips. This year the Auxiliary's 50th Aniversary is being celebrated by the about 90,000 members in 1,200 county auxiliaries. The 50 year history, *THE RIGHT SIDE OF THE CADUCEUS* is available at the national office and its "story of the years" provides interesting reading.

The 50th Anniversary Convention House of Delegates, held in San Francisco last June, called for a complete revision of our national Bylaws. The appointed Structure Review Committee and the Bylaws Committee have spent many hours on the proposed revision to be presented to the June Convention in New York City. Needed attention will be given to membership requirements. The AMA is also stressing membership and last year residents and interns were formally invited to become regular AMA members with annual dues of $20.00 which brings them a series of benefits and a voice in AMA policy development. Both the AMA and Auxiliary can benefit from young leadership, participation and support.

To help keep you informed we have year's Program Workbook which gives ideas, guidance and suggestions to state officers and chairmen who are to relay the material to the counties. Package Programs are available at the national office.

The "Direct Line Newsletters" give current information to the county presidents. *MD's Wife* magazine tells our story to members and others who are interested. There is a Fall Conference that is an officer's training conference. The four regional Fall Workshops provide program-exchange opportunities for selected committees. When special needs arise other special meetings are provided as the Big Cities Clinic which studied the problems and needs of the large urban areas. The year will close with the Annual Convention in June in New York City. Also in New York a new year will be launched . . . a year that will provide opportunities for service.

"No matter what your age or job in life, you are more mature if you have found a

'cause' in which to invest your time and money for some social good," wrote Dr. William Menninger. "Through it you can achieve an outstanding characteristic of emotional maturity — the ability to find satisfaction in giving." The Auxiliary gives to YOU the opportunities to invest in people and ideas . . . your tokens of faith, and "faith ultimately makes it possible to overcome the seemingly insurmountable."

Where Are We? Where Are We Going? Who Will Be Driving? – Emergency Medical Services In Rural Nebraska . . .

C. G. GROSS, M.D.

WHERE are we? Where are we we going? Who will be driving? Perhaps these questions can best be dealt with by considering them in the context of the basic components of the ideal emergency medical system. These basic components are (1) transportation facilities, (2) trained personnel, (3) communications, (4) definitive care facilities, and (5) organization. These components will be the same whether the system functions in the rural or metropolitan area, even though the emphasis may change depending upon the situation. Because my experience has been limited to rural systems, that aspect will be emphasized in the following remarks.

Well, where are we with transportation? Ambulance design has changed considerably in the last few years. Due to a considerable amount of work by individuals in the country and in our state, recommendations for change in ambulance design have been made on both the federal and state level. The new recommendations suggest a vehicle that resembles a carryall or van-type vehicle, more than the station wagon or hearse that have been used in the past. This type of vehicle configuration makes it much easier to handle the patient within the vehicle. The equipment suggested for use of the attendants has also been expanded, and this type of vehicle makes it easier to store and use this added equipment. These changes have added to the cost of this equipment considerably, however there are federal and state matching funds available to aid in financing if the specifications are met. If local funds are severely limited, of course a converted van - type vehicle or station wagon can be utilized, but will not serve as efficiently. The future may hold other forms of transportation such as helicopters, but at least at the present it would seem that ground vehicles will be the mainstay for routine use in the foreseeable future.

How are we doing with trained personnel? This area has also changed in the last several years. As you are well aware, prior to the discontinuation of ambulance services by funeral directors, there was no real training for its attendants. Since that time, with cities and other governmental subdivisions acquiring the responsibility of emergency medical services, many of these services are operated by volunteers, and most of these volunteers have been coming from the volunteer fire departments in the state. These individuals are highly motivated people and have some background training. However, there has not been any standard course which has been applicable to ambulance emergency situations. In the last two or three years, there have been several courses devised and the State of Nebraska is presently attempting to train ambulance attendants. These are now being designated as emergency medical tech-

nicians (EMT). A standard course is being taught by people who have been trained through the Department of Health and the Nebraska Fire Service. The current course is 72 hours and covers the areas that the EMT will face in day-to-day operation of the rescue vehicle. Ten hours of in-hospital training is also suggested, but is not required for certification. The time in the hospital is devoted to familiarizing the trainee with hospital procedure, and acquainting him with the definitive care of the patient. Following the completion of the course, an examination is given and the trainee is then certified as an Emergency Medical Technician. Currently, there are many more people who are interested in taking these courses than there are instructors, and therefore physicians in the community are needed as instructors. This requires some amount of time, but it is very rewarding.

We have found that the individuals who have taken this course are very interested in the work and are very interested in continuing to update their skills. Therefore, some provision seems desirable to continue some type of refresher program or continuing education for these people. In our area, it has worked well to have meetings at approximately one month intervals, at which time the EMTs have reviewed previous skills or new situations are presented to them for practice. Some of these have included practicing extricating one another from automobiles, applying splints, and reviewing cardiopulmonary resuscitation procedures. An especially popular program has been to demonstrate the effects of anoxia and resuscitation procedures on an anesthetized dog. This can also include practice at starting intravenous fluids and endotracheal intubation. We also feel that the review of actual cases is helpful to the EMT. X-rays and definitive care of the trauma cases can be reviewed, so that they have an idea of what happens to the patient after he arrives at the hospital.

Where would we like to be going with further training? As of today, about 500 of the 3,400 ambulance attendants in the state are EMT trained. Getting all of these people trained seems a reasonable goal, along with furnishing more advanced and refresher courses for the previous graduates. This will be a formidable task and will need help, cooperation, and continued leadership from the medical profession in the state.

Where are we with communications? The statewide designation and implementation of FM radio communication has greatly aided the rural emergency medical system. This has given the ambulance attendant reliable communication with his dispatcher, hospital, and other emergency vehicles over distances of 50 miles or more. A typical local system can include a base station, usually in the hospital, mobile units in the ambulances, with units in physicians' automobiles if desired. With this system, the dispatcher at the base station usually receives the request for emergency services by telephone and relays it to the ambulance. This may be accomplished by telephone or signal such as a fire siren. He then maintains communication during the whole time the patient is being evaluated, treated, and transported. The radio is also useful in interhospital transportation, in that the ambulance can communicate with the hospital before arrival of the patient, and receive instructions. With enlarged use of the systems in the state, it will become obviously more efficient in dispatching and interhospital communications, thus a statewide communication network should be encouraged.

We can foresee in the not too distant future that radio communication might become very helpful in biological telemetry such as transmitting electrocardiograms or other biological data to the hospital. This can provide information to the physician at the hospital, along with return communication to the personnel at the scene. With this capability, it would appear that the patient could thus be given more accurate and more rapid treatment at the scene. In any case, a reliable radio system is now available and is becoming a very critical component of the rural emergency system.

Perhaps the largest area for improvement and change will be the organization of emergency services. I'm sure that we can all

agree that rapid, efficient care of the patient is our goal. The only discussion seems to be in the way we reach that goal. Certainly, there are many ways to approach the problem, but currently one alternative would appear to be establishment of emergency medical councils. These councils can be established on all levels of activity, from the local rescue squad to state and nationwide areas. The local council should consist of a physician if possible, representatives of the local hospital, fire department, rescue squad, law enforcement, and someone knowledgeable in radio communication. Other segments of the community can certainly be represented, but those mentioned would appear to be a minimum. I can personally assure you that these local councils are by far the easiest way to establish the type of system that we have been talking about. They can provide organization for the day-to-day operation of the system, as well as a means of planning for the future on the local level. If multicity, county, or regional councils are established, the same type of representation is desirable. Representatives of the local councils can be utilized on these larger councils to provide representation of the different areas of function. Thus, ideas and input from varying points of view are possible with greater chance of innovation. On a local or regional level, it would appear that these councils could work for better communication in interhospital planning and generally more efficient utilization of the system. They can also be very helpful in stimulating and supporting continuing personnel education. We have found that the people who are interested in improving emergency medical services are very interested in professional guidance. Therefore it would seem that this offers an excellent opportunity for leadership from the medical profession in this area. It would appear with our professional guidance and with local and regional planning and cooperation, a truly uniformly efficient system should be within reach.

The medical facility component of the emergency medical services will not be discussed today. This is not because it is less important than the others, but time does not permit. Obviously changes and improvements should be occurring in the emergency rooms of the hospital as the other portions of emergency medical services improve. I'm sure that there will be continuing changes and improvements, and this is an area where we must continually be alert for change and improvement.

In closing, I would like to share with you some practical information concerning help in acquiring the sort of system we have been discussing. The Department of Emergency Health Services of the State Department of Health, headed by Mr. Milton Parker, can be of invaluable aid in all aspects of establishing and maintaining the system. Besides good advice, they have been helpful in matching fund programs for ambulances, equipment, and radios. The EMT program is also administered through this department. We have found the department most interested in local problems and anxious to help. Dr. Kimball has been a leader in this program for years, and I'm sure that he would make himself available to share his considerable knowledge and experience at any time.

Finally, I would like to share this thought with you. If today you have the feeling that your emergency medical services are adequate in your community, as you drive home, give some serious consideration to the situation in which members of your rescue squad would come upon you or your family in an automobile accident. If you feel that these individuals and the system that you have could cope with the situation adequately, then perhaps no more work or attention is needed in your area. If you have some doubt that perhaps some areas could be improved, I would urge you to take an interest in your local emergency medical services.

Where are we? Where are we going? Who will be driving? It is up to us.

Some of the Less Known Side Effects of Rifampin in Therapy of Tuberculosis*

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RIFAMPIN, one of the newer antituberculosis drugs, has been shown to be extremely effective against *Mycobacterium tuberculosis in vitro* as well as *in vivo*.[1,2] It is a semisynthetic compound belonging to the group of Rifamycins. In 1957 various Rifamycins were isolated from the fermentation broth of *Streptomyces mediterranei*. Further study of Rifamycins resulted in the development of Rifampin in the research laboratories of Lepetit S.p.A., Milan, Italy. It was immediately shown that this compound possessed significant tuberculostatic properties. After the advent of Rifampin it became increasingly possible to treat tuberculous patients at home. It also became evident that this drug could be used as a companion drug to isonicotinic acid hydrazide (INH) in the intermittent (biweekly) high dose antituberculous therapy of unreliable patients. The drug is well absorbed after oral administration, attains high concentrations in the plasma and is excreted slowly. After a single dose of 600 mg on an empty stomach, mean peak plasma concentration is about 7 mcg/ml in 90 minutes, and detectable levels are present after nine hours.[1] The major side effects of Rifampin on daily therapy have been gastric intolerance, jaundice, and relative neutropenia. The jaundice is more likely to occur in alcoholics.[3] In several hundred clinical isolates, Verbist and Gyselen[1] found no *in vitro* cross-resistance between Rifampin and any of the other antituberculous drugs.

The incidence of naturally resistant mutants unresponsive to higher concentrations of Rifampin is very low — 10 to 100 times less than for INH or streptomycin.[1]

However, certain potentially serious side effects of Rifampin have become increasingly apparent in the course of intermittent high dose therapy of tuberculosis, utilizing this drug in combination with other antituberculous drugs like INH, streptomycin or Ethambutol (EMB).

These side effects are described below:

a. *Thrombocytopenia:*

This was first reported by Blajchman et al[4] in a patient receiving biweekly high dose Rifampin (1200 mg) and EMB. This patient presented with epistaxis and bleeding into the lips and tongue. Two other cases of thrombocytopenia related to Rifampin were subsequently reported.[5] These patients had asymptomatic thrombocytopenia. In all these cases antibodies against Rifampin were demonstrated in the serum. Platelet complement fixation and direct antiglobulin tests were positive in the case of the patient with symptomatic thrombocytopenia. Indirect antiglobulin test was positive in all the three patients. The mechanism of thrombocytopenia in the above instances has been thought to be immunologic.[4,5] The drug acts as a hapten. It combines with macromolecules in the plasma and becomes antigenic. Antibodies are produced against the drug. When the drug is given again, it forms a hapten-antibody complex which is adsorbed on the surface of the platelet and/or red cell membrane and binds complement. The platelet destruction is thought to be mediated by complement. Even though positive direct and indirect antiglobulin tests have been observed in these patients, immune hemolysis has not been reported so far in

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patients receiving Rifampin. The antibodies against Rifampin may belong to either the IgM or IgG immunoglobulin class.

b. *Febrile reaction:*

Another untoward reaction related to Rifampin therapy has been a febrile syndrome with pyrexia (37.2 - 40.5° C), malaise, rigors, nausea and vomiting. Myalgia may be prominent in some cases. Rise in blood pressure was observed in some patients.[5] In one instance, the febrile reaction was associated with temporary renal failure.[5] In one series, 16% of the patients receiving intermittent high dose Rifampin therapy experienced the febrile syndrome;[5] only one patient in this group failed to reveal antibodies against the drug. It has been postulated that the drug — antibody complex binding complement in the serum is the cause of the febrile syndrome.[5]

Poole et al[5] observed that the Rifampin dependent antibodies developed more readily in females (56%) than in males. They also observed that the antibodies could appear before the onset of the side effects. There was no relationship between the titer of the antibody and the presence or absence of symptoms. There was also no relationship between the duration of Rifampin therapy and the development of antibodies against the drug. One-third of their patients on intermittent high dose Rifampin therapy developed antibodies against the drug. Usually these patients had received three months of daily therapy before the intermittent high dose Rifampin therapy was started and the antibodies were observed.

Nilsson[6] showed that addition of Rifampin to the medium significantly inhibited *in vitro* blast transformation of human lymphocyte cultures by Phytohaemagglutinin (PHA). He also showed that *in vitro* blast transformation of lymphocytes from tuberculin positive donors by purified protein derivative tuberculin was inhibited by Rifampin in the same medium.

At this time *in vivo* significance of this finding has not been determined.

Grassi et al[7] have also observed significant inhibition of *in vitro* blast transformation of human lymphocytes by PHA if Rifampin were simultaneously present in the culture medium. When Rifampin was added to the medium 24-48 hours after the addition of PHA no inhibition of blast transformation was observed. These results indicate that Rifampin can suppress desoxyribonucleic acid (DNA) and protein synthesis in the lymphocytes. These investigators[7] also noted that guinea pigs previously inoculated with Freunds complete adjuvant exhibited a marked inhibition of the tuberculin skin reaction while receiving Rifampin therapy.

From the foregoing, it becomes apparent that Rifampin, though a potent antituberculous drug with many advantages, has some potentially serious side effects in larger doses and when used in intermittent therapy for tuberculosis. If the *in vitro* immunosuppressant effect of this drug has significant *in vivo* correlation, it may be unfavorable in a disease where cellular immunity plays the major role in host defense.

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The Jacksonville Emergency Medical System

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THE City of Jacksonville, Florida, with a population of 532,000 people, has developed an Emergency Medical System, which has been termed by many experts as the finest in the country. Yet less than five years ago, the ambulance situation was chaotic, with numerous underfinanced private companies and funeral homes competing for business and offering a very poor quality of service. As a result of a campaign by the news media, rising public opinion, and the inauguration of a new Consolidated County-City government, the situation has been corrected in a short time. This was made possible by the cooperation of government and organized medicine, combined with stiff regulatory provisions for private ambulance operations and a takeover by the Fire Department of all *emergency* ambulance service.

Nearly all calls for emergency medical service come from the scene into the Fire Department Emergency Operation Center, from either home phones or special emergency phones mounted on street corners. This center has direct phone lines and radio communications with all hospital emergency departments in the City, and with the switchboard of the County Medical Society. Time punch cards are kept on each run, as well as 24-hour tape records of all communications. Ten Rescue Squads are distributed throughout the city so that the average running time to the scene was 4.2 minutes in 1969-1970. It has slowly risen over the past two years, due to an expanding population moving toward the city limits, and now exceeds six minutes. However as we shall see later, the first trained help on the scene arrives in an average of 4-5 minutes.

The ambulances have a roomy box-type medical body mounted on a one-ton chassis, and are fully equipped as mobile emergency rooms. At 50,000 mile intervals, the body is lifted off, the worn chassis replaced by a new one, and we have a new ambulance. Cost for a ten year period is approximately half that of a limousine type ambulance.

Four of these ten rescue ambulances are based on hospitals to afford inhospital training to the rescue personnel, and to provide better ambulance-hospital coordination. The crews are rotated at periodic intervals so that many men, over the long term, spend an average of five months each year based on the hospitals. Cooperation between the personnel and hospital emergency staffs is extremely close.

Training of the Emergency Medical Technicians is extensive, starting with the EMT course given all firemen recruits at the Fire School. Formerly the 30 hour American Red Cross Advanced Course, it has now been expended to include the 80 hour Department of Transportation Emergency Medical Care course. Advanced lectures in various medical subjects are then given by physicians and over 50 have participated in the program. Inhospital training follows for those going into rescue and EMTs spend hundreds of onduty hours in hospital emergency departments. Practical work includes observing childbirths and autopsies, taking EKGs, drawing blood, and working as a part of the Cardiac Resuscitation Team. On duty formalized exercises and frequent written tests are required, as are periodic lecture series after hours by physicians. A number of the men are enrolled in the evening division of Florida Junior College in a 60 semester hour Associate Arts degree program in Emergency Medical Technology, perhaps the first of its kind in the nation. One result of the extensive training program has been the ability of the city to obtain

malpractice insurance for all EMTs in the amount of $5,000,000 for an annual premium of slightly over $8,000.

Overall medical supervision of the medical training program is the responsibility of the Chief Fire Surgeon, Dr. Roy M. Baker, a prominent cardiologist who serves at a pay of one dollar per year. He is assisted by ten Assistant Fire Surgeons, all one dollar a year volunteers, who act as advisors to each squad, help in the instruction, and monitor their performance to insure quality control. Each Fire Surgeon has a two-way fire department radio in his private car, and is on call to answer serious emergencies whenever he is on the streets. The dedication of these men and women reflects the outlook of our entire medical community on emergency care.

The most rewarding result has been in the reduction of the automobile death rate. After arrival at the scene, first priority is placed on checking the victim's airway, and stopping bleeding before any attempt is made to move him. If serious injury is suspected, an IV blood expander such as lactated Ringer's solution is started to combat shock. Medical advice is instantly available from the hospitals by direct ambulance-hospital radio communications.

We should be very clear that the emergency medical technician (EMT) at the scene, with the radioed advice of the hospital physician, is making diagnoses and he is rendering *treatment,* not merely first aid. The procedure has the full blessing of the great majority of our physicians, and is sanctioned by an amendment to the Florida Medical Practices Act passed in 1970 by the legislature at the urging of the Florida Medical Association. That such an advance has occurred in less than five years is a tribute both to the quality of emergency care rendered by the Rescue Branch and to the forward looking attitude of our medical professionals. While IVs can be started at the initiative of the EMT, the administration of drugs must be prescribed by radio or phone by a physician.

After initial stabilization, great emphasis is placed on proper extrication and use of backboards. Patients are kept on these backboards until x-rays are taken. Spare backboards are available at the hospitals, and the amublance can be quickly back in service by use of this economical "Letterman System." By stabilizing the patient at the scene before transportation, and then carefully extricating him less than five percent of the runs from the scene of the accident to the hospital are done at high speed with light and siren. Enroute, the patient is given antishock therapy and monitored on an oscilloscope if required. The hospital is warned ahead of time of the nature, vital signs, and ETA of any serious case. In severe cases, the patient can be left wired to the oscilloscope until a physician examines him and OKs his transfer to the emergency room. A form is filled out on each patient detailing the treatment of the case.

Due to the advanced notice given the emergency departments, and the fact that four of them have emergency practice groups present at all times (a fifth is a large teaching hospital with full ED manning), little delay is encountered in beginning treatment at the hospital on serious casualties.

The results in reducing the death rate in automobile trauma victims has been spectacular. Prior to initiation of this program, it was generally believed by recognized medical authorities that the provision of rapid and effective treatment on scene could reduce automobile trauma deaths by 20%. How has the Jacksonville system done?

In 1968, when we initiated the program, we had 15,846 accidents, involving approximately 8,669 injuries, and 131 deaths. In 1971, the number of accidents yearly increased to an estimated 22,500 (based on 11 months printouts), with an estimated 12,-380 injuries, but the deaths dropped to 117! The save rate on injured victims was 99%. In terms of deaths per thousand accidents, the reduction was from 8.27 to only 5.2- a reduction of 38%, or nearly twice that predicted by medical experts. In contrast, the number of auto deaths in the State of Florida rose 7.8% in 1971.

Much of this reduction has to be attributed to our advanced emergency medical system. Of course, the increasing number of post-1967 cars, with new safety features such as collapsible steering columns, breakout windshields, padded interiors, etc., have had their effect as has a beefed-up highway law enforcement system; yet in the surrounding seven rural counties, where new cars are also involved, the death rate per thousand accidents was 23.4 in 1970, or over four times Jacksonville's present rate. These counties lack sophisticated emergency care systems, and the observer is forced to the conclusion that this constitutes the primary reason for the vast difference in death rates.

The practice of on scene diagnosis and advanced treatment has had another marked effect. Prior to 1968, nearly all victims were placed in an ambulance and rushed at high speed to a hospital, where many turned out to be suffering from only minor injuries. In 1971, our Rescue units responded to 18,204 calls for help. Yet they transported only 8,427 to hospitals; the rest either required no treatment, or were treated on scene and released, or allowed to go to a doctor or hospital by automobile. The reduction in load on the emergency departments and Rescue Branch is significant.

While 117 people died last year in Jacksonville in automobile accidents, over 1600 died of heart and CV disease. Nationally, a large percentage of these deaths are occurring outside the hospitals. The overall death rate on initial myocardial infarction is approximately 25 percent; but, once in the intensive care units of the hospitals, the rate drops to approximately 15 percent. It is a shocking fact that 60% of those who die of a heart attack in the United States die outside the hospital without a doctor in attendance. To increase the rate of survival outside the hospital, our Rescue ambulances have been fitted with special cardiac gear and rescue crewmen given special training in treatment of cardiac cases, including defibrillation; cardiopulmonary resuscitation, and when prescribed by a physician, the administration of drugs. Two-way radio communications can be maintained with a physician in the emergency room, and all of the ambulances are equipped to telemeter EKG's by radio. On all suspected heart attack cases, two ambulances (or an ambulance and a fire engine) are dispatched to provide the manpower necessary to carry out life sustaining procedures.

Unfortunately, our statistics on heart attacks are not as complete as those on automobile trauma, and we are now preparing to conduct a more complete study of results for the year 1973. However, a brief overview of the suspected heart cases for April 1972 are enlightening.

382 Dispatches were made during April 1972 by the Jacksonville Fire and Rescue Operations Center controllers based on calls from citizens reporting symptoms suggestive of heart attacks or breathing difficulty. Usual assignment was on one Rescue and one Fire Company.

150 Patients (39%) were not transported. 23 were dead before arrival of Rescue, and not considered viable for CPR. 19 of these were presumed CV victims, while 4 died of other known causes. Yet, arrival time of Rescue unit averaged only 5.9 minutes after alert of these 23 cases; however, some victims had been dead as long as three hours, and seven were believed dead over one hour. 127 other patients were treated or reassured on scene, evaluated as non-emergency and not transported to a hospital.

232 Cases (61%) were transported to hospitals. 85 of these were transported for emergencies other than suspected cardiovascular episodes. 138 were transported with symptoms suggestive of respiratory/heart difficulties. Of these 138 patients, 26 experienced arrest or arrhythmia at the scene or enroute, and required CPA, and in some cases IV medication and defibrillation.

Twelve of these 26 CPR cases were pronounced DOA at the hospitals. Fourteen were viable on arrival and full resuscitation measures taken by hospital resuscitation teams. In 9 of the 14 cases, success was not achieved. Resuscitation was maintained in five patients, but one died in the CCU after 24 hours; four were ultimately discharged home. The long term survival rate in CPR patients was 15.4%.

112 suspected CV patients were delivered viable to hospitals without necessity for CPR or defibrillation measures. This group was later categorized by the hospitals, in terms of primary illness, as follows:

Heart disease	54	(6 died)
Pulmonary disorders	11	
CVA	11	(7 died)
Hysteria	5	
Hypertension	3	
Other	17	(2 died)
Final diagnosis and outcome unobtainable	11	

The data was clouded by the fact that of the 19 dead at the scene, the 12 classified as DOA at the hospital, and the 9 cases not converted in the ED, cause of death was in most cases not confirmed by autopsy. Histories were often unavailable.

Of the 99 known or assumed heart patients, 19 were dead before help arrived; 12 died before hospital arrival; 9 died in the emergency department; 7 died in the CCU. Fifty-two survived, including 4 resuscitated by CPR.

This one month audit confirms the high cardiac death rate outside the hospitals (46%) and the high incidents of death in the first hour. The excessive delay in notification after onset of symptoms is notable, with the common fatal results. The 15.4% long term survival following CPR is consistent with other studies. Only 26% of the cases reporting cardiac or breathing difficulties were ultimately diagnosed or presumed to be heart cases. Although 20% of all Rescue dispatches are for suspected heart cases, this would indicate that only 5.2% of the calls coming into Control involve *actual* cardiac cases. Despite this small percentage of the total load, the high attendant mortality rate justifies the emphasis placed by the Rescue Branch and the Fire Department on cardiac care.

Ten rescue squads and four medically equipped Quick Response Squads are thus available to aid citizens in distress, far in excess of the resources usually available in a city of our population. However, we were aware of the fact that in a city of 840 square miles, we still had time and distance problems. We turned our attention to the fire fighting companies (combat), of which we had 49 in 41 stations, strategically distributed throughout the city. Why not use these, which were often nearest an accident, to render aid until a rescue unit arrived? Firemen have historically been underutilized, yet they must be ready 24 hours a day waiting for an alarm. In 1971, we adopted a formal policy of dispatching a combat company along with a rescue squad on all serious medical cases. Trained in comprehensive first aid and carrying first aid kits and oxygen, they can initiate treatment until a rescue unit arrives with even more sophisticated equipment and EMTs, who can transport the victim if required.

In 1972, over a third of all responses by combat companies involved medical emergencies rather than fire. In a number of cases, their prompt arrival definitely saved lives. In taking this step, we have placed the full resources of our Fire Department and its thousand men at the disposal of our citizens who are stricken, rather than just the 100 plus men in Rescue and the QRS units. It is a practice that is here to stay, and one that every citizen in the nation should consider.

A nominal charge of $22.50 is made by the Rescue Branch when a patient is transported; no charge is made if he is treated on scene and released. The charge is more a deterrant to needless calls than a revenue source. The cost to the citizens of Jacksonville for this superb rescue service is $1.53 yearly per capita in tax dollars. It is one tax expenditure that brings no public criticism. In over four years of operation, only five written complaints have been made about the service.

Despite the great strides we have made, there are still problems.

Here, as nationally, we are continually faced with delays of one to six hours after the onset of symptoms before the heart attack victim seeks help. All too often it is then too late. The best team in the world can do nothing for a man who has been dead ten minutes.

Our rescue service has probably been more publicized than any in the nation, and we have mailed emergency telephone number stickers to all of our citizens. Yet, in January 1972, 23% of the people seeking emergency medical rescue service called our police department; the fire control center,

which handles rescue, got the message second hand.

Furthermore, ten percent of fire alarm calls were actually made to the police department.

We are deeply concerned that a year's study of heart attack patients admitted to five of our city hospitals showed that 67% of them drove to the hospital by automobile instead of calling the Rescue Branch — an extremely dangerous practice that cost a number of lives. Yet, the American Heart Association advises in case of a heart attack first contacting your doctor, and, if unable to do that, to go to the hospital immediately. This may be practical advice in some areas where ambulance service is poor, or doctors can be reached immediately, but it isn't in Jacksonville and we are advising our citizens to *first of all* call 355-8833. Our Rescue Branch and Fire Department will respond immediately and notify the person's doctor if requested.

Due to our highly effective rescue system, and the network of high speed highways throughout the city, we have few occasions to use medical evacuation helicopters within the city limits. Three large Naval Air Stations here have seven helicopters available, and are most cooperative in providing them to us on short notice for evacuating patients from the surrounding rural counties. The Army National Guard unit has over 15 modern helicopters available, and will provide them when crews are available during weekend drills. Heliports are available at three major hospitals in the city.

Under our agreement with the Navy, our Rescue Branch provides the EMTs and medical equipment, while they provide the helicopter and crew. In the past year, a number of successful medical evacuations have been made following a request from one of our surrounding rural counties. A critical test came in February 1971, when a tremendous explosion at the Thiokol plant in Southeast Georgia killed or injured over 80 people. In an isolated area, with only three doctors in the county, outside aid was the only hope. Jacksonville Fire Control Center took control of the operation, dispatching ground rescue units, four Navy helicopters, a police helicopter, and numerous doctors and EMTs. Patients were triaged at the scene and loaded onto helicopters for rapid transportation to Jacksonville hospitals, where surgical teams were mobilized and waiting. Twenty-seven critical patients were brought in by land and air, and 26 survived. When the last patient arrived less than two hours after the first alert, the northside hospital complex still had surgical and bed capabilities to handle 80 more patients.

The major urban centers with their great hospitals must extend help to our rural areas, and the helicopter is an ideal transportation vehicle for such medical evacuations. Due to the tremendous operating expense of large helicopters capable of carrying prone patients, it is obvious that most of them must be provided by the military rather than the states and cities. Utilizing the communication, control, and medical facilities of a major city system, combined with a military airlift capability, we have the know-how today to quickly set up an areawide model. During the past year, over 70 groups from other cities and states have visited Jacksonville to observe our system, and its components have been copied and implemented in many other areas. We believe that our capability should be extended to the surrounding rural areas as a model of an urban-rural area EMS system, and requested federal funding for such a project.

In July 1972, following a competition with over 60 other states and areas, Jacksonville and the surrounding seven rural counties of Northeast Florida were selected as one of five model project sites to demonstrate means of delivering emergency medical care to the rural population as well as to the ghetto indigent population. The planning and implementation of this project is well underway and the project will become operational on July 1, 1973. It involves a comprehensive systems approach to replace the fragmented emergency medical care now being delivered. In addition to the training of ambulance crews as advanced emergency medical technicians, every fireman

and policeman in the eight county area will be trained in first aid and fire and police vehicles will carry first aid equipment. Modern modular ambulances completely equipped are being provided in the rural counties together with trained personnel to man them. In each county a somewhat different approach to manning is planned in order to afford a variety of experimental approaches in the project area. The manning ranges all the way from full time fire department personnel to volunteer personnel and we are especially interested in the use of the EMTs as part of the hospital staff in the small community hospitals. For this purpose we are hiring a number of former military medics and they will function in the hospital as well as take out the ambulance on emergency runs. We are developing a comprehensive communications system which will include radio in each hospital, and communications with the ambulances and with the physicians on call by use of mobile two-way radios. We are beefing up the emergency rooms and staffing in the community hospital level as well as greatly augmenting University Hospital as a major trauma and critical illness receiving center. When we are ready to go we are going to engage in a vast public information program to educate the maximum number of citizens in how to obtain access to the system. As the system goes into operation we will have a sophisticated data collection and analysis system to appraise us of the functioning in return on the system. We are very optimistic that within the year the eight county system will be receiving the same kind of attention that the Jacksonville system is receiving today.

The Specialist

THE THORACIC SURGEON

When I was a resident, which is a wonderful way to reminisce and lose an audience, I once collected all the thoracotomies that had been done in our university hospital for several years, and found that they had averaged only 10 cases a year. Today they probably do that many every day.

But this is the age of the chest cutter, who views any operation below the diaphragm with disdain. First they lopped off the outsides of tumors, then when anesthesia made chest surgery possible, they performed pneumonectomy and lobectomy; then came mediastinal procedures and finally operations on the heart, including transplantation.

If you make a hole in a person's chest wall, he may die; the lung on that side collapses. So they put the patient in a negative pressure chamber, with his head sticking out; then they made the chamber bigger and bigger, until the surgeon and his assistants could fit inside. Then came the anesthesiologist with his endotracheal tube, which he cuffed or packed, and he told the surgeons they could throw away the negative pressure chamber, which had now become a truck. He simply substituted his positive pressure for their negative one, and thoracic surgery was on the way. Of course, Matas had suggested this long ago.

A leading thinker had once said that you could do anything you liked, but he had only contempt for anyone who would ever think about operating on the heart. We began with patent ductus and went on to coronary arteries and valve replacements.

Patients with lung cancer used to be put out on the ward to die. Now we radiate and of course we operate. The mortality rate is very high, but it is no longer a hundred percent. And many who had what once was thought to be cancer are now found, on exploration, to have benign resectable lesions. And there are chest injuries, what with knife wounds, bullet wounds, and crushing.

Thoracic surgery was a long time coming, but it is here to stay. For we have with us cancer, tuberculosis, tracheoesophageal fistula, empyema, rheumatic and arteriosclerotic heart disease, congenital cardiac defects, and many other pathological entities that cried out for help when it was death to enter the chest, and when it was done rarely, and is now done so commonly, so easily, and so safely.

—F.C.

Picture Gallery

Photos taken at the Nebraska High School Team Physicians Seminar. The Seminar took place at the Radisson Cornhusker Hotel on November 3rd, 1973.

The speakers were Doctor Paul Goetowski, Team Physician, University of Nebraska—Lincoln; Doctor F. Miles Skultety, Professor of Neurosurgery and Neuroanatomy, University of Nebraska College of Medicine; and O. Max Jardon, M.D., Assistant Professor, Department of Orthopedic Surgery, University of Nebraska College of Medicine.

Doctor Stanley M. Bach, a member of the NMA Sub-Committee on Athletic Injuries and Team Physician, University of Nebraska —Omaha, served as moderator.

Forty Nebraska physicians were in attendance at the Seminar.

While Making Rounds

What To Do About The Energy Crisis.

Do what Simon says.

On The Autonomic Nervous System.

White with anger.
Livid with rage.

On Anabolism.

"A man is the same man although there is not an atom in his body which was there five years before."

E. P. Mitchell

Pediatrics: Question Time.

Do babies get scabies?
Do babies get rabies?

Dedicated to the memory of Lewis Carroll.

Words We Can Do Without.

In the context of, pervasive, cohort study.

Quote Unquote.

"The A.M.A. has awarded a plague."

Department Of Statistics.

Fire killed approximately 11,900 people in this country last year.

Diagnosis.

"Low income."

This Month.

February 19, 1962: Papanicolaou died.

Disease For Today.

Nail-patella syndrome.

The Letter.

"Removed a fisher."

The Chart.

"He colpassed."

He either passed out cold or he collapsed.

Cole's Law For This Month.

No matter what you bring your car to the garage for, when you get it back, the clock will not work.

Names, Just Names.

Morel first said dementia praecox, in 1860; he called it demence precoce.

Bleuler introduced the term schizophrenia, in 1911, and I wish he had left well enough alone. It's a terrible word, even if the disease is not dementia or insanity, and is not praecox, or of the young. I wish psychiatrists would define psychosis for me; what I learned in medical school doesn't seem right today, and the dictionary definitions are no better: any mental disorder, and deeper behavior disorders, and break with reality.

On The Function Of Pain.

"Pain is useless to the pained."
Galen.

Well, I touched a hot stove spot and pulled my hand back quickly, and because of the pain, which was gone in seconds, I escaped without injury.

Section On Also-Known-As.

Whistler's *Mother* is really called Arrangement in Gray and Black.

Debussy's *Clair de Lune*, which gives me so much trouble, is only a part of his Suite Bergamasque.

Rembrandt's *The Night Watch* was originally named The Shooting Company of Captain Frans Banning Cocq. The picture got dark, so they changed its name.

Clair de Lune means moonlight, and Beethoven's *Moonlight Sonata* is actually called Sonata Quasi una Fantasia; this gives me trouble, too.

Chopin's *Minute Waltz* is really the D flat

Waltz, of which I think there are two, and is the Little Dog Waltz.

There is a Chopin *Cat Waltz,* too; its story reminds me of Kitten on the Keys.

The Physical.

"Left sided weakness in his lower extremities."

Omar said it first, I know
But still I thought you'd like to know.

"We dance round in a ring and suppose
But the Secret sits in the middle and knows."

Frost.

—F.C.

Our Medical Schools

Postgraduate course: ophthalmology

Ophthalmology for non-ophthalmologists will be the topic of a postgraduate course at the University of Nebraska Medical Center Thursday and Friday, February 7 and 8.

Guest faculty will include Dr. George S. Twyner, Lubbock, Texas.

Topics to be covered will be visual acuity testing, cataracts, glaucoma, contact lenses, diabetes, and pediatric ophthalmology.

Dr. Raymond Records, professor of ophthalmology and chairman of the department, is coordinator of the course.

Registration fee of $50 includes two luncheons.

The course is approved for 11 hours of credit by the American Academy of Family Practice.

Sessions will be in the Center for Continuing Education, Omaha.

Continuing education

March schedule for the Continuing Education Center at the University of Nebraska Medical Center:

1. A program dealing with emotional problems encountered in family practice will be presented March 6 in Scottsbluff and in Omaha March 8.

   Guest faculty includes Cheryl Blakeway, coordinator of psyciatric services at St. Joseph Hospital, Omaha, and Joyce Lierley, mental health nurse at the Great Plains Mental Health Center, North Platte, Nebraska.

   The Scottsbluff program, cosponsored by the Panhandle Mental Health Center, will be held at the Ramada Inn. The Omaha presentation will be at the Center for Continuing Education on the Medical Center campus.

   Course coordinator is Dr. William B. Long, assistant professor of psychiatry and family practice.

   The course is acceptable for 7 prescribed hours by the American Academy of Family Practice.

   The registration fee of $25 includes luncheon.

2. A course on March 8-10 will focus on principles of facial plastic surgery.

   Dr. M. Eugene Tardy, Jr., associate professor of otolaryngology at the University of Illinois (Abraham Lincoln School of Medicine) will be on the guest faculty.

   The tuition fee of $125 includes lunches.

   Dr. Anthony Yonkers, associate professor and vice chairman of the department of otolaryngology and maxillofacial surgery, is coordinator of the course, which is acceptable for 21 prescribed hours of credit by the AAFP. It will be on the Medical Center campus.

3. Creighton University School of Medicine will cosponsor a program on obstetrics and gynecology Thursday and Friday, March 14 and 15, at the Medical Center.

   Guest faculty includes Dr. Charles E. Flowers, Jr., professor and chairman of the department of obstetrics and gynecology, University of Alabama; Dr. Howard G. McQuarrie, assistant clinical professor of obstetrics and gynecology, University of Utah Medical Center; Dr. Richard F. Mattingly, professor and chairman of the department of obstetrics and gynecology, Marquette University School of Medicine; Dr. George W. Mitchell, professor and chairman, department of obstetrics and gynecology, Tufts University School of Medicine; Dr. J. George Moore, professor and chairman, department of obstetrics and gynecology, University of California School of Medicine (Los Angeles).

   The course is acceptable for 12 prescribed hours by the AAFP.

   The registration fee of $50 includes lunches.

   Course coordinator is Dr. Joseph C. Scott, Jr., professor of obstetrics and gynecology and vice chairman of the department.

4. A course on emergency medicine is designed for physicians interested in the immediate management of emergency patients coming into the hospital.

   Guest faculty of the March 21 and 22 course will be Dr. John A. Otto, emergency physician at Childrens Memorial Hospital, Omaha, and Dr. Brent Scott, emergency physician at the Immanuel Medical Center, Omaha.

   Registration fee of $50 includes two luncheons. The course is acceptable for 15 prescribed hours by the AAFP. It will be on the Medical Center campus.

5. The American College of Cardiology will co-sponsor a program on high blood pressure March 28 through 30 in the Center for Continuing Education.

   Guest faculty members are: Dr. Henry W. Blackburn, Jr., director of the laboratory of physiological hygiene, University of Minnesota; Dr. Theodore Cooper, director, National Heart and Lung Institute; Dr. Marvin I. Dunn, director of the Cardiovascular laboratory, University of Kansas School of Medicine; Dr. James C. Hunt, professor of medicine, Mayo Medical School; Dr. John H. Laragh, professor of clinical medicine, Columbia University College of Physicians and Surgeons and director of the hypertension center, Columbia-Presbyterian Medical Center, New York City; Col. William P. Nelson, chief of cardiology service, Fitzsimmons General Hospital, Denver; Dr. Michael H. Sketch, co-director of the division of cardiology at Creighton University School of Medicine; Dr. Robert C. Tarazi, staff member, research division, Cleveland (Ohio) Clinic Foundation; Dr. Gordon H. Williams, associate professor of medicine, Harvard Medical School and director of the endocrine-metabolic unit, Peter Bent Brigham Hospital, Boston.

   Registration is $100 for members of the College of Cardiology and $150 for non-members.

   The program is acceptable for 18 prescribed hours by the AAFP.

   Program directors are Dr. Robert S. Eliot, professor of internal medicine and director of the division of cardiology; Dr. Gerald Wolf, assistant professor of pharmacology and radiology and director of radiology research, and Dr. Francis L. Land, professor and chairman of the department of family practice, all at the UN Medical Center.

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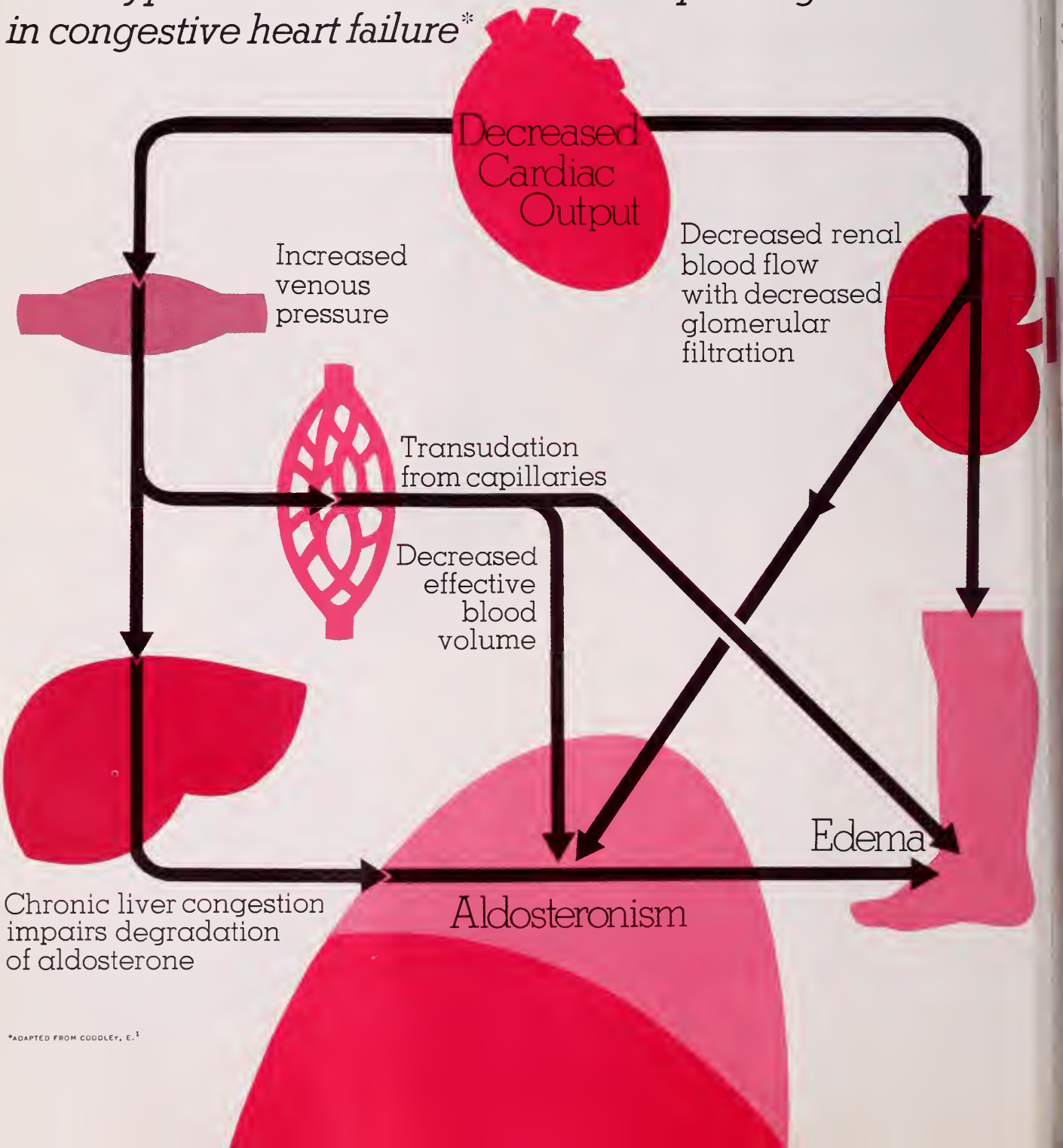

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- Avoids potassium loss.

2. As the basic daily diuretic with an "add-on" alternate-day-diuretic ("A.D.D." schedule)

- Can be administered daily as basic therapy with the additional agent (furosemide or ethacrynic acid) given every second or third day.
- Aldactone plus "A.D.D." schedule minimizes potassium deficiency and potentiates effect of "add-on" diuretic.[2]
- Avoids acute volume depletion and aldosterone rebound.[2]

3. As a daily diuretic in combination with a daily dose of a thiazide

- Permits daily additive diuretic effect while maintaining potassium balance.

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: **1.** Coadley, E.: Consultant 12:106-107, 109, 111, 113, 115 (July) 1972. **2.** Thorn, G. W., and Louler, D. P.: Am. J. Med. 53:673-684 (Nov.) 1972.

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Down Memory Lane

1. Have our obstetrical patients today reason to fear childbearing?

2. Since July, 1919, we have had on our statute books one of the finest laws ever passed in the history of our state, viz., the law requiring that every child in our public schools shall be inspected during the first month of the school year to determine defects of the eye, the ear, the nose and the teeth.

3. His comment was that the failures to get relief from the symptoms complained of by removing a tumor of the spinal cord were far less than the failures to remove right abdominal pain by removal of the appendix.

4. A compensible injury is the result of force, directly or indirectly applied and sufficient to produce a recognizable disturbance of physical or mental function, with or without visible change in bodily contour.

5. That the patient will not follow directions, is no excuse for the doctor.

6. The treatment of non-institutional cases of tuberculosis is largely a matter of psychiatry.

7. It is interesting to notice the numerous malpractice suits brought against members of the medical profession and those in allied work.

8. Can medicine afford publicity? Is there anything about the methods of practice the public should not know?

9. The latest medical specialty seems to be moonshining and bootlegging — whereat we blush.

10. The industrial surgeon plays a dual role. He serves the employer most when he serves the employee best.

Nebraska State Medical Journal
February, 1924

In Memoriam

DR. EVERETT E. ANGLE

Doctor Everett E. Angle died on December 2, 1973 at the age of 77. Doctor Angle was born in Lincoln on January 13, 1896.

He was graduated from the University of Nebraska in 1918 and received his medical degree from Harvard Medical School in 1921.

He served as President of the Lancaster County Medical Society and in 1943 as President of the South Central Section of the American Urological Association.

Doctor Angle retired from practice in 1971 having practiced in urology since 1924. He was presented the Nebraska Medical Association fifty-year pin in 1971.

He is survived by sons, John C. Angle of New York City; Dr. William D. Angle of Omaha; Edward E. Angle of Camarillo, California; sisters, Mrs. Guy (Florence) Reed of Long Grove, Illinois; and Mrs. Harry (Evelyn) Stevens of Fremont; and seven grandchildren.

DR. WILLIAM C. NIEHAUS

Doctor William C. Niehaus died at the age of 47 on December 17, 1973. Doctor Niehaus was born in Superior, Nebraska on September 24, 1926.

He graduated from the University of Nebraska College of Medicine in 1953 and practiced in David City, Nebraska until 1970. In that year, he became the Director of Emergency Services at Bishop Clarkson Memorial Hospital in Omaha.

Survivors include his widow, Beverly Ann; son, William C. Niehaus II; daughter, Lisa Ann, all of Omaha; mother, Mrs. R. J. Nie-

haus of Superior, Nebraska; and brother, John L. Niehaus of Phoenix, Arizona.

DR. V. ROBERT WATSON

Doctor V. Robert Watson died on November 3, 1973 at the age of 47. Doctor Watson was born in 1926 in Oakes, North Dakota.

He graduated from the University of South Dakota in 1950 and from the University of Nebraska College of Medicine in 1954.

Doctor Watson began his medical practice in Seward in 1955. He was a veteran of World War II and was a member of the Nebraska Academy of Family Physicians.

Surviving are his wife, Ruth; a son, Robert; a daughter, Jane; and a sister, Mrs. Ivan Blevens.

WashingtoNotes

HMO

Little noticed amid congressional confusion in attempting to deal with the energy crisis was the passage of a major health bill shortly before adjournment. The bill provides $375 million over five years to support the development of Health Maintenance Organizations (HMOs) across the country.

If signed into law by the President, the HMO legislation will go far in determining both consumer and provider acceptance of prepaid group health care. Despite a substantial flow of federal dollars into the experimental program, HMOs are not expected to encounter easy sailing. Ardent supporters of the program admit the trial period will be a rough one and caution against over-optimism.

Copayments were barred under the Senate bill. However the conference agreed to allow HMOs to charge nominal copayments, but not to the extent they could be considered a barrier to seeking treatment. The conference committee said the copayments are aimed at enabling an HMO "to market its benefit package at a competitive price."

The final bill requires larger employers to offer workers an HMO option when existing contracts for health insurance expire provided that a qualified HMO is operating in the area.

The bill does not provide a specific number of HMOs, but the bill's legislative history indicates the Congress had in mind about 100 programs.

PSRO

Rep. John Rarick (D., La.), principal congressional sponsor of legislation to repeal the Professional Standards Review Organization (PSRO) program, has dispatched a letter to all members of the House urging their support.

In his letter, Rarick said PSRO "is the hottest controversy facing medical doctors and their patients. The AMA House of Delegates recently voted to seek congressional repeal of this controversial peer-review law that goes into effect on 1 January 1974."

Rarick quoted AMA President-elect Malcolm C. Todd, M.D., as calling PSRO "the greatest threat to the private practice of medicine of any piece of legislation ever passed by congress."

Pharmaceutical and prescribing

Sen. Edward Kennedy's Health Subcommittee hearings on the drug industry lived up to their explosive expectations with HEW Secretary Casper Weinberger throwing the first bomb by announcing that the Administration would propose a cost-saving drug plan for Medicare and Medicaid patients under which reimbursement would be limited to "the lowest cost at which the drug is generally available."

Estimating the savings at from $25 to $60 millions a year, the HEW proposal was a blow to the pharmaceutical industry which viewed it as a step toward generic prescribing and a set back to the brand name concept. Sen. Gaylord Nelson (D., Wis.), said the HEW recommendation "must be only the first step in a massive intrusion by the federal government into the prescribing habits of physicians."

The first day's session featured charges that drug companies are monopolistic, keep prices jacked high, and spend huge amounts on advertising. Physicians were described as inept and too generous prescribers of drugs influenced inordinately by advertising and drug detail men.

Sen. Gaylord Nelson (D., Wis.), a subcommittee member, urged that prescription drug advertising be banned and trade names eliminated. Consumer advocate Ralph Nader agreed and recommended patent restriction.

C. Joseph Stetler, President of the Pharmaceutical Manufacturers Association, testified that, "What the secretary is proposing represents an extraordinarily radical approach to health care, one which may give the appearance of providing first class medical care at less cost, but which will either require Medicare and Medicaid beneficiaries to accept inferior products or force them to pay the cost of first class medicines from their own household budgets."

Stetler said the proposal might have some merit if therapeutic equivalence of drugs could be assured, "but the published evidence is almost entirely on the other side. Reports of the clinical inequivalence of drugs sold under the same generic name are increasing as are quality control failures."

In his slashing testimony, Sen. Nelson said the AMA "has cooperated in creating confusion" and has been "disastrous in this field because the custodians of health care in this country are the guide to us on what good medical practice is." The AMA "has done more damage to the good practice of drug prescribing than if it did not exist at all," Nelson said. The AMA's drug manual was "degraded" due to pressure from drug companies . . . "For money! It is as simple as that," he asserted.

National health insurance

The first round of congressional hearings on National Health Insurance (NHI) concluded following a week of testimony from experts in the health-economic field who laid a general philosophical foundation for full-scale legislative sessions early in the new year.

Energy

The Administration has moved to set clear fuel priorities in the health field as Congress was warned by health leaders that emergency care, drugs and devices and hospital care could be severely affected unless sufficient fuel is made available this winter.

A spokesman for the AMA testified there is a critical need to make special provisions for an adequate supply of motor fuel to meet the needs of medicine. J. Cuthbert Owens, M.D., a member of the AMA Commission on Emergency Medical Services, said, "Physicians, nurses, life support personnel, rescue workers, and ambulances and other emergency motor vehicles must have a sufficient and continuous supply of gasoline to insure the provision of prompt care for the ill and injured. In addition, adequate fuel must be available to health care institutions, as well as to suppliers of necessary medical equipment and supplies."

Coming Meetings

CRIPPLED CHILDREN'S CLINICS —
February 2 — Scottsbluff, St. Mary's Hospital
March 2 — Kearney, Elks Lodge
March 23 — Sidney, Elks Lodge

SYMPOSIA MEDICA FOUNDATION presents an International Conference on Clinical Problems in Ophthalmology and Otolaryngology to be held in Jerusalem, February 14-24, 1974. For further information, contact: Ms. Cynthia Soika, M.A., Projects Director, Symposia Medica Foundation, 305 East 24th Street, New York, N.Y. 10010.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS — February 21-23, 1974, 17th Congress on Administration, Palmer House, Chicago.

NEBRASKA MEDICAL ASSOCIATION — Annual Session, April 28 - May 1, 1974, Omaha Hilton Hotel, Omaha, Nebraska.

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS — 22nd Annual Clinical Meeting, April 29 through May 2, 1974, Las Vegas, Nevada. Registration fee for non-members: $125.00. Contact: Mr. Donald F. Richardson, Associate Director, The American College of Obstetricians and Gynecologists, One East Wacker Drive, Chicago, Illinois 60601.

AMERICAN MEDICAL ASSOCIATION — Annual Session, June 22 - 27, 1974, Chicago, Illinois.

NEBRASKA MEDICAL ASSOCIATION — Fall Session, October 3 - 5, 1974.

AMERICAN MEDICAL ASSOCIATION — 28th Clinical Convention, December 1 - 4, 1974, Portland, Oregon.

SCHEDULE OF UPCOMING NCME PROGRAMS

January 28 - February 10

THE CASE OF THE TINGLING HAND.

MONONUCLEOSIS IN THE CLINIC AND THE LAB.

PRIMARY TREATMENT OF SOFT TISSUE INJURIES: VARIATIONS IN CHILDREN.

February 11 - February 24

PAUL D. WHITE: CARDIOLOGY IN MY TIME.

THE DISTRESSED NEWBORN: THE FIRST 30 MINUTES.

February 25 - March 10

TREATMENT OF PULMONARY EMBOLISM.

THE FIVE-MINUTE JOINT EXAM.

DETECTING OPEN ANGLE GLAUCOMA.

Medicinews

HMO conference

House and Senate conferees have reached final agreement on S. 14, the Health Maintenance Organization Act of 1973. The bill, which closely follows the House passed version, authorizes to be appropriated $325 million over five years for grants, contracts, and loans for feasibility surveys, planning, initial development, and initial operating expenses for HMOs. The bill contains provisions authorizing an override of any state law which would restrict or prohibit the development of HMOs for those HMOs which meet the criteria established in the bill and which receive assistance under the program. The bill contains requirements that each HMO develop organizational arrangements for an ongoing quality assurance program for its health services which stresses health outcomes and provides review by physicians and other health professionals of the process followed in the provision of health services. Deleted were provisions which were part of the Senate passed bill authorizing a separate National Commission on Quality Health Care Assurance. The bill contains provisions requiring the Secretary to contract with a non-profit private organization for study and recommendations regarding various quality assurance programs. Action by the House or Senate on the Conference Report is not expected until the second session of the 93rd Congress.

VA reappoints Dr. Musser

Reappointment of Dr. Marc J. Musser, an alumnus of the University of Wisconsin, as chief medical director of the Veterans Administration, was announced recently by Donald E. Johnson, Administrator of Veterans Affairs.

Dr. Musser was originally named to the position on January 5, 1970, when he became the seventh chief medical director since the modern VA Department of Medicine and Surgery was established by law in January 1946. His reappointment, extending to January 1978, provides a tenure of service matched by only one predecessor, Dr. William S. Middleton, VA Chief Medical Director from 1955 to 1963, who also has a long association with Wisconsin medicine.

As Chief Medical Director, Dr. Musser will continue to direct the largest medical complex in the nation. The VA medical system includes 170 hospitals and 205 outpatient clinics, and employs 7,600 regular-salaried physicians as well as 20,000 nurses.

Dr. Musser, 63, received his B.A. degree in 1932 and his M.D. degree in 1934, both from the University of Wisconsin. Following internship at the Kansas City (Mo.) General Hospital, he completed his residency in medicine and neurospsychiatry at the University of Wisconsin and then joined the university's medical school faculty in 1938.

He returned to the university medical teaching staff following four years Army service in World War II during which he attained the rank of colonel and commanded the 135th Medical Group overseas. He first joined the VA in 1957 as a member of the Houston VA hospital staff where he also served as a professor of medicine at the Baylor University School of Medicine.

Dr. Middleton was a faculty member at the University of Wisconsin medical school for 43 years and served as its dean from 1935 to 1955. In 1960, he was named Emeritus Dean and Emeritus Professor of Medicine and was further honored when the medical school named a new library after him in 1967. He is presently a consultant in research and education at the VA hospital at Madison.

A former deputy chief medical director of the VA, Dr. Musser left the agency to establish and direct the North Carolina Regional Medical Program and also to chair a steering committee providing coordination for all of the nation's 55 regional medical programs. In the four years prior to his 1970 return to VA as chief medical director, he

also served as professor of medicine at the Duke University School of Medicine and the Charles Bowman Center of Wake Forest University.

Drug hearings

The Senate Health Subcommittee has conducted two days of hearings to review major issues regarding the manufacture and use of drugs. Appearing on behalf of the American Medical Association was James H. Sammons, M.D., Chairman of the Board of Trustees. Doctor Sammons reviewed AMA activities in the area of drug evaluation and education, and pointed to the publication of the second edition of *AMA Drug Evaluations*, observing also that the Association journals are a valuable source of information regarding drug therapy. With respect to proposals which would restrict the attending physician's discretion in prescribing drugs, Doctor Sammons emphasized that broad latitude must be allowed in drug therapy and that the physician must be able to prescribe drugs in the dosage and strengths deemed appropriate for his patient. Doctor Sammons stressed that the attending physician is in the best position to make decisions regarding the treatment of his individual patients. Noting that no single drugs for any disease can be tolerated by everyone, much less be effective in all people, he opposed the adoption of any formulary which would restrict the physician's choice of therapeutic agents to a selected list of drugs. With respect to prescribing, Doctor Sammons said that "it is imperative that the physician be free to prescribe using generic or brand name designation, but at the same time we have urged physicians to take into account cost considerations as well." In discussing the role of the package insert in the regulation of drug marketing he pointed out that the information is limited, that it does not encompass all that is known or published about the drug, and should not be construed as a mechanism for regulating medical practice. With respect to cooperation with the FDA in the discharge of its duties he said, "we believe that the views of practicing physician should play a large role in the decisions vitally affecting medical practice and patient care." He called for increased budgetary support for FDA so that the agency would have sufficient resources to carry out its mission.

HEW Secretary, Caspar W. Weinberger unveiled an Administration proposal to limit drug reimbursement in federal programs to the "lowest cost at which the drug is generally available." The Secretary stated, "that in terms of quality and therapeutic equivalence, with few exceptions, no significant differences among chemical drugs has been shown." "We believe," he said, "that this reimbursement policy will result in significant savings on the cost of providing prescription drugs under Medicare and Medicaid." Mr. Weinberger, voicing the Administration's opposition to a restrictive drug formulary said, "It is not the business of government to tell doctors what marketed drugs they may or may not prescribe." He did, however, outline a project for the development of a compendium listing all drugs with data regarding method of administration, indications, contraindications, side effects, warnings, and prices. Specific information regarding the new policy of drug reimbursement has not yet been released.

Books

Books reviewed

Women in the Work Force; edited by Mildred E. Katzell, Ph.D. and William C. Byham, Ph.D.; 76 pages; 14½ by 21½ cm (5½ by 8½ in.); hard cover; $7.95; published 1972 by Behavioral Publications, New York.

There are 7 chapters, by 7 authors, who define the pressures for change, the militance of women, and their increasing educational skills; and who then say what they are doing to bring about equal employment. No index.

—F.C.

Handbook of Surgery, edited by John L. Wilson, M.D.; 11 by 17.5 cm (4¼ by 7 in.); 877 pages; limp cover; $7.00; published December 1973 by Lange Medical Publications, Los Altos, California.

This is the fifth edition of the Handbook, which first appeared in 1960. The book is divided into

20 chapters, written by 21 authors. There is an appendix, and a good index.

The print is good, the text is up to date, and the book is just small enough to serve as a vade mecum and will go into a house officer's white-coat pocket or a surgeon's auto glove compartment.

There are the usual illustrations and tables. The list of authors is impressive.

Recommended, and a good buy.

—F.C.

Books received

Before Addiction; How to Help Youth; by Florence Lieberman, DSW; Phyllis Caroff, DSW; and Mary Gottesfeld, MSS; 131 pages; hardbound; $7.95; published 1973 by Behavioral Publications, New York.

Crisis Intervention; edited by Gerald A. Specter, Ph.D., and William L. Claiborn, Ph.D.; 210 pages; softbound; $4.95; published 1973 by Behavioral Publications, New York.

The Letter Box

May 14, 1973

Dear Dr. Cole:

For months I have been tempted to inquire why The Nebraska Medical Journal still carries a 1964 copyright, instead of a 1973 copyright.

We receive the Journal in our office, and enjoy it.

Sincerely,

Sheldon B. Smith
Editor
U.S. Medicine

December 17, 1973

Dear Dr. Cole:

Glad to see you changed the copyright.

Merry Christmas.

Sincerely

Sheldon B. Smith
Editor
U.S. Medicine

Effects of Overweight on Cardiovascular Diseases — T. Gordon (Biometrics Research Branch, National Heart Institute, Bethesda, MD 20014) and W. B. Kannel. Geriatrics 28:80-92 (Aug) 1973.

The Framingham Study, which provides the basis for this report, is a long-term sampling of 5,209 adults, 30 to 59 years of age, living in the town of Framingham, Mass., from 1948 through 1949. Every two years since enrollment in the study, they have been offered a thorough, standardized cardiovascular examination. This report is based on the first 18 years of follow-up for the measurement of risk attributes and, in general, the first 16 years of cardiovascular events. The average subject at Framingham was roughly 30% above ideal weight. In both men and women, a greater relative weight is associated with a higher incidence of cardiovascular disease. However, fatter men are less likely than leaner ones to manifest intermittent claudication. It is reasonable to argue that the effect of weight is mediated through its influence on blood lipids, blood pressure, and carbohydrate tolerance.

EEG Changes Due to Exposure to Organochlorine Insecticides — A. Mayersdorf (Kupat Holim, Negev District, Beer Sheba, Israel) and R. Israeli. Harefuah 85:307-309 (Oct 1) 1973.

Of 73 workmen continuously exposed to organochlorine insecticides, 16 had abnormal EEG tracings. The most severe changes were noted in those exposed to organochlorine insecticides for one to two years. Some of the records showed bitemporal sharp waves with shifting lateralization and with low-voltage, diffuse theta activity. Paroxysmal discharges composed of slow and sharp waves, most pronounced anteriorly, spike-wave complexes, and posteriorly located, low-voltage, rhythmic spikes were demonstrated in other records. None of those examined showed either abnormal neurologic features or clinical convulsions. The electrophysiological changes are most probably due to abnormal central nervous system ammonia metabolism.

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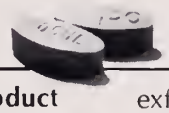

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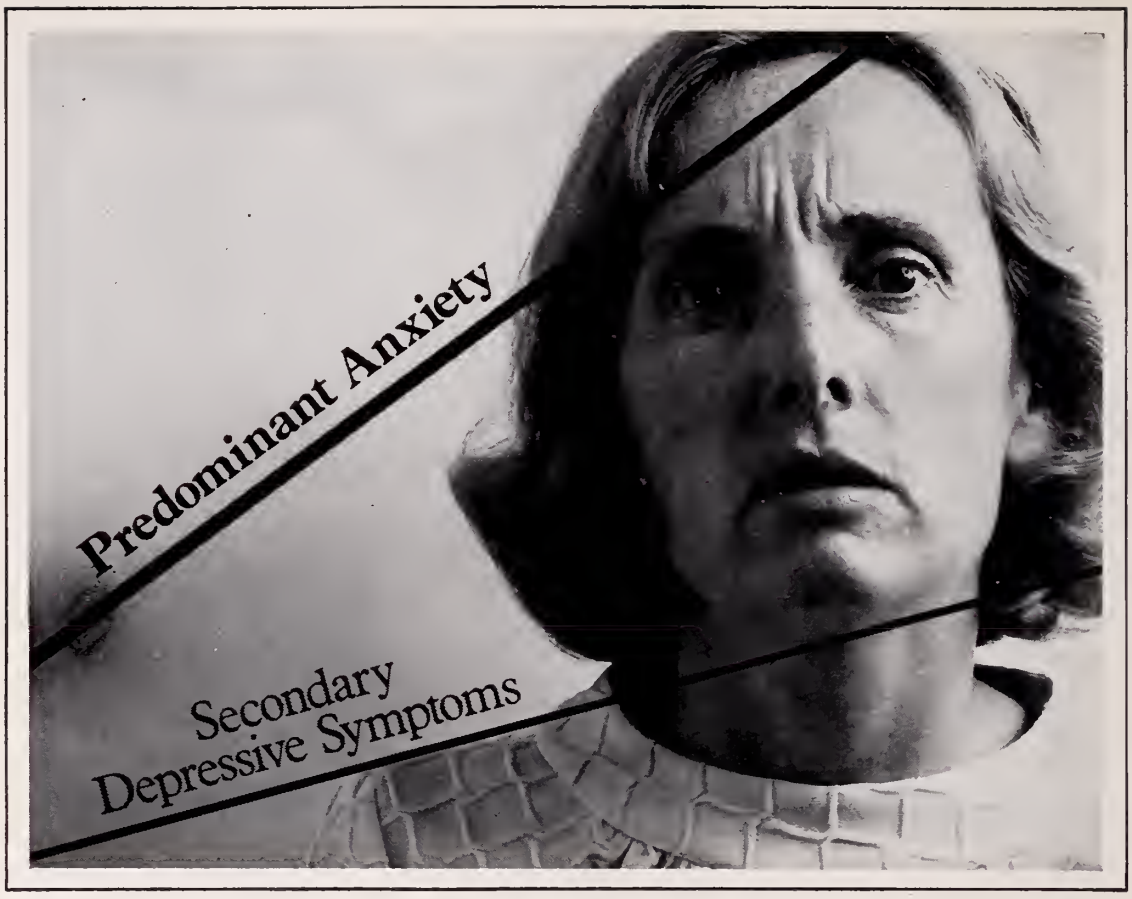

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

When you determine that the depressive symptoms are associated with or secondary to predominant anxiety in the psychoneurotic patient, consider Valium (diazepam) in addition to reassurance and counseling, for the psychotherapeutic support it provides. As anxiety is relieved, the depressive symptoms referable to it are also often relieved or reduced.

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Tuesday, Apr. 30, NMA Sessions Feature Symposium on Gynecologic Cancer

George C. Lewis, Jr., M.D., of Philadelphia, Penn., and Donn G. Mosser, M.D., Minneapolis, Minn. present the Symposium on Gynecologic Cancer at the 1974 NMA Annual Session.

Dr. Lewis is currently Professor of Obstetrics and Gynecology at Jefferson Medical College, Thomas Jefferson University, and active on the staff of Thomas Jefferson University Hospital.

Dr. Mosser is Director of Radiation Therapy at Northwestern Hospital, Minneapolis, Minn. He serves as Clinical Professor of Radiation Therapy at the University of Minnesota.

GEORGE C. LEWIS, JR., M.D.

DONN G. MOSSER, M.D.

Symposium on Antibiotics

W. Eugene Sanders, Jr., M.D., and Malcom T. Foster, Jr., M.D., Omaha physicians, appear in the Symposium on Antibiotics, Tuesday afternoon at the NMA Annual Session.

Dr. Sanders will discuss the "Newer Antibiotics — Fact or Folklore" and Dr. Foster will discuss "Venereal Antibiotics."

Plan to attend both Tuesday Symposiums at your NMA Annual Session.

Medicinews . . .

Keogh clears ways and means

The House Ways and Means Committee has completed its work on H.R. 2, the Employee Benefit Security Act. As reported by the Committee, the bill would liberalize the present Keogh program to permit the setting aside of 15% of income, or $7,500, whichever is less, in an approved pension program. The House proposal is the same as the Senate-passed version in that it would permit professional corporations to set aside an amount which would result in a pension equal to 75% of an individual's high three years of income, with the pension limited to a maximum of $75,000 a year . . . The Ways and Means proposal, and one approved by the House Education and Labor Committee, is scheduled to go to the House Rules Committee soon, at which time a combined bill will be worked out and a rule granted. However, the rule could provide for a separate floor vote on the Keogh and professional corporation provisions.

ADVICE TO AUTHORS

The Editor of this Journal assumes no responsibility for opinions and claims expressed in the articles published herein.

Manuscripts to be presented for publication in the JOURNAL should be typewritten, double-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title-page should be shown the title of the article, the name (or names) of the author, his degree and other significant credits. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Illustrations should be numbered and their locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be in black (India ink) on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

Manuscripts (original, not a carbon) should be sent directly to the Editor at the Journal's address.

Letters to the Editor submitted for publication should be prepared as above, and must carry the notation: To be Published.

Reprints should be ordered from the printer, Norfolk Printing Co., Inc., P. O. Box 278, Norfolk, Nebr. 68701.

Scalp Hair Patterning as Clue to Early Fetal Brain Development — D. W. Smith (RR234, Health Sciences Bldg, RD-20, Univ of Washington, Seattle 98195) and B. T. Gong. J Pediatr 83:374-380 (Sept) 1973.

The authors present the following hypothesis: Scalp hair patterning is determined at 10 to 16 weeks of fetal life and is secondary to the growth and shape of tissues, which underlie the fetal skin, especially the brain. Thus, aberrant scalp hair patterning may be utilized as a clinical indicator of aberrant growth or shape of the early fetal brain prior to 16 weeks' gestation.

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Renal Autotransplantation in Treatment of Bilateral Renal Artery Stenosis: Relief of Hypertension in 8-Year-Old Boy — A. Sinaiko et al (Dept of Pediatrics and Pharmacology, Univ of Minnesota, Minneapolis 55455). J Pediatr 83:409-413 (Sept) 1973.

An 8-year-old boy was found to have hypertension and bilateral renal artery stenosis at 3 years of age. The blood pressure elevation was unresponsive to vigorous antihypertensive therapy. Surgical correction of the renal artery stenosis by renal autotransplantation was associated with the return of blood pressure to normal.

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What's on your patient's face...

may be more important than his chief complaint

Patient P.T.* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.

Patient P.T.* seen on 6/12/67, seven weeks after discontinuation of 5% FU cream. Reaction has subsided. Residual scarring not seen except that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J

The lesions on his face are solar/actinic— so-called "senile" keratoses... and they may be premalignant.

Solar, actinic or senile keratoses

These lesions may be called by several names, but they usually can be identified by the following characteristics. The typical lesion is flat or slightly elevated, of a brownish or reddish color, papular, dry, rough, adherent and sharply defined. They commonly occur as multiple lesions, chiefly on the exposed portions of the skin.

Sequence of therapy— selectivity of response

After several days of therapy with Efudex® (fluorouracil), erythema may begin to appear in the area of the lesions; this reaction usually reaches its height of unsightliness and discomfort within two weeks, declining after discontinuation of therapy. This reaction occurs in affected areas. Since the response is so predictable, lesions that do not respond should be biopsied.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

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New Jejunostomy Feed — J. T. Hindmarsh (Sheffield Univ, Sheffield, England) and R. G. Clark. Br Med J 3:609-611 (Sept 22) 1973.

After preliminary evaluation on seven patients after gastric surgery, a jejunostomy feed described by the authors was used as the sole means of feeding three patients with duodenal fistulae for 14, 21, and 23 days respectively. Sodium, potassium, and nitrogen balances became normal, diarrhea did not develop and body weight increased; the composition of the feed compared favorably with that of the ideal jejunostomy feed used previously.

Phenformin and Pulmonary Hypertension — M. Fahlen et al (Sahlgren's Hosp, Goteborg, Sweden). Br Heart J 35:824-828 (Aug) 1973.

Two cases with clinical signs of pulmonary hypertension and right heart failure developing during phenformin treatment are reported. The patients were clinically improved on withdrawal of phenformin. Two possible explanations for the pulmonary hypertension were considered: cellular anaerobiosis or alphareceptor stimulation of the pulmonary vessels.

First-Rank Symptoms, Severity of Illness, and Treatment Response in Schizophrenia — R. Abrams (New York Medical College, New York 10029) and M. Taylor. Compr Psychiatry 14:353-355 (July-Aug) 1973.

Seventy-one hospitalized patients received the discharge diagnosis of schizophrenia. A "blind" assessment was made of the presence of Schneider's First-Rank Symptoms (FRS) of schizophrenia, and ratings of the severity of illness and the immediate response to treatment. No relation was found between the presence or absence of FRS and either severity of illness or treatment response. This finding supports previous studies ascribing diagnostic specificity to FRS independent of other illness variables.

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Double Endoscopy of Esophagus and Bronchi in 1000 Cases of Carcinoma of Esophagus — A. Chavy et al (l'Institut Gustave-Roussy, Villejuif, France). Ann Gastroenterol Hepatol 9:319-326 (No. 4) 1973.

From June 1959 to December 1971, 1,000 patients with esophageal cancers had double endoscopy (esophagoscopy and bronchoscopy) at the same time. Tracheal or bronchial lesions were found in about half (48.4%) of the patients. Bronchoscopy is an important investigation in cancer of the esophagus because tracheal or bronchial lesions are contraindications for surgical treatment and sometimes for x-ray therapy.

Surgical Management of Preinfarction Syndrome — E. A. Traad et al (Miami Heart Institute, Miami Beach, FL 33140). Ann Thorac Surg 16:261-272 (Sept) 1973.

Preinfarction syndrome is characterized by rapidly progressive angina, exacerbation of previously stable angina, and recurrent bouts of coronary insufficiency. During a three-year period 60 patients with this syndrome ranging in age between 30 and 72 years underwent urgent or emergency bypass procedures. Eight patients sustained early, and five late myocardial infarction with one and three deaths. respectively. Of the 56 survivors only two continue to have incapacitating angina.

Impaired Lymphocyte Transformation in Hodgkin Disease: Evidence for Depletion of Circulating T-Lymphocytes — K. M. Matchett et al (VA Hosp, Durham, NC 27705). J Clin Invest 52:1908-1917 (Aug) 1973.

Peripheral blood lymphocyte transformation stimulated by phytohemagglutinin (PHA) was found to be depressed in all patients with Hodgkin disease (HD), including those with localized disease and no symptoms. Most patients with HD had an increased number of cells circulating in their blood, which were actively synthesizing DNA.

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Relationship of Androgens to Female Hirsutism and Infertility — R. L. Rosenfield (Biomedical Center for Population Research, Univ of Chicago Pritzker School of Medicine, Chicago 60637). J Reprod Med 11:87-95 (Sept) 1973.

Most plasma androgens circulate bound to testosterone-binding globulin (TeBG). The unbound (free) fraction of plasma androgens appears to be the biologically active portion though it represents only about 1% of the total. Moderately severe, male-pattern hirsutism is usually a subtle hyperandrogenic state which is indicated in 85% of women by elevated free plasma androgen levels. Measurement of urinary 17-ketosteroids reflects hyperandrogenism in only 10% of women. Free plasma androgen levels are more often abnormally high than measurement of total plasma androgens would indicate because a low TeBG titer is characteristic of hirsutism. Overproduction of androgens by the ovary is more closely related to infertility than is that by the adrenal.

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Sarcoidosis of Upper Lung Fields Simulating Pulmonary Tuberculosis — A. S. Teirstein (70 E 90th St, New York 10028) and L. E. Siltzbach. Chest 64:303-308 (Sept) 1973.

Fifty-four of 616 patients (9%) with sarcoidosis exhibited upper lung field radiographic abnormalities, which mimicked adult tuberculosis. Difficulty in diagnosis occurred when patients had residual upper zonal shadows which persisted after clearing lower and midzonal densities. Awareness that upper zonal sarcoidosis represents a residual manifestation of the more usual pattern of hilar adenopathy and diffuse lower and midzonal infiltrations, aids in distinguishing this radiographic pattern from that of adult tuberculosis. Obtaining a radiograph dating back to an earlier stage can be crucial in making this differentiation.

Evaluation of Lung Uptake of Colloid During Liver Imaging — J. W. Keyes, Jr., et al (Strong Memorial Hosp, Rochester, NY 14642). J Nucl Med 14:687-691 (Sept) 1973.

Marked lung accumulation of activity was visualized on routine liver scanning in a group of 22 patients in whom colloid variations, bone marrow uptake, and blood pool activity could be eliminated as contributing factors. The only common findings were the presence of some type of liver disease and a poor prognosis. Clinical and laboratory evidence points to either an alteration in the pattern of reticuloendothelial system activity or rapid in vivo clumping and pulmonary microembolization.

New and Simple Test of Nerve Function in Hand — S. O'Riain (Children's Hosp Dublin). Br Med J 3:615-616 (Sept 22) 1973.

Approximately 30 patients with peripheral nerve injuries in the upper limb had the hands and forearm immersed in water at 40 C for 30 minutes and it was noticed that the normal skin wrinkled or shriveled, while the denervated skin remained quite smooth. The accuracy of localization of nerve lesions by this simple method was confirmed at exploration.

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References: 1. Martin, E.W., et al., ed.: Hazards of Medication, Philadelphia, J.B. Lippincott Co., 1971, p. 511. **2.** Seegmiller, J.E.: Med. Clin. North Amer. 45:1259-1272 (Sept.) 1961.

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The Executive Board of the American Academy of Neurology

The Committee on Drugs of the American Academy of Pediatrics

The American College of Allergists

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The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association

Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

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DON'T COUGH AT ME

I am nothing less than an authority on the subject, because I have observed people in the act of coughing for many years. I am writing about those you meet in everyday life, in offices, restaurants, and theaters, and wherever else you go; I do not mean the ones to be found in hospitals.

And I have concluded that well over nine tenths of everyday-encountered coughs are needless and useless. They have no purpose, they can be suppressed, and they serve only to irritate the already distressed respiratory system of the cougher.

But what is worse is the universal custom of habitual coughers of refusing to cover their mouths while they indulge in their offensive practice, so that the sea of air that surrounds them, and in which I willy-nilly find myself, becomes infested with whatever pathogenic microorganisms have infected the cougher.

These miscreants do not cough at random or to all points of the compass; no, they wait until you are near, and then they *aim* at you.

One cough leads to another, and the first bark in a room filled with these villains leads to a chain reaction.

And I have noticed a curious habit among coughing wretches: coughes come in twos. Nobody coughs once and stops; no, it goes cough, cough; then it is the next fellow's turn.

In the world of the future, the only punishable crime may be having tuberculosis, and the penalty for coughing may be confinement and meditation. There is as much to be said for those addicted to chronic and overly enthusiastic noseblowing, but the coughers are worse.

F.C.

WHAT'S GOOD FOR PEOPLE

HEW apparently plans to limit reimbursement for prescription drugs provided under Medicare and Medicaid to the lowest cost at which the drugs are available, which would usually be generic rather than brand-name.

The philosophy is based on the idea that chemical equivalence is the same as therapeutic equivalence. This is not always so, and when it is not true, the policy may condemn Medicare and Medicaid patients to inferior health care.

It can be argued that the concept of generic equivalence is an oversimplification, and that HEW has applied a concept to the health of Medicare and Medicaid patients that it would hesitate to use with whiskey or golf balls.

Buying cheap things to save money is like turning off the fire alarm to put out the fire or even like stopping the clock to save time; cheap drugs may prove to be expensive.

The generic versus brand name argument has been with us for some time. If I favor brand, I favor quality. Is a Volkswagen the same as a Cadillac? They are both automobiles. You may argue that the least expensive car is good enough, but I can reply that below-standard drugs may not always be safe drugs.

The doctor should be free to prescribe generic, if *that* is what he wants; or brand name, if *that* is what he wants.

F.C.

NOTHING CHANGES

The human body is a wonderful thing, and it is made up of all sorts of little pieces, and homeostasis. In this way, nothing changes, except that we grow old, and we die. But from one day to the next, we do not change. We change only at class reunions, where we all look older.

But if our faces wrinkle and sag, and our bellywalls protrude, everything else stays the same. Height is fixed, weight increases ever so slightly, and temperature is constant.

What goes in? Food, drink, air, microorganisms, heat, and sound.

What comes out? Breath, urine, sweat, feces, tears, cerumen, saliva, microorganisms, nasal and bronchial secretions, semen, heat, and sound; and occasionally, babies.

What does both? Air, water, heat, sound, semen, bacteria and other tiny living things such as fungi and worms and viruses, and food residue.

What goes in and what comes out strike an exact balance, down to the last c.c., milligram, calorie, centimeter, and decibel.

Do we breathe in more than we breathe out? Does more water come out than goes in? It all stays the same. If it did not, we should swell or shrink, and we would die. But come to think of it, we do.

F.C.

LIFE IN THESE UNITED STATES

I turned on the TV game and there was the Star Spangled Banner, which I like. Now when you take the card personality test, they include several questions to see if you are telling the truth. One asks if your table manners are the same when you eat alone as they are when you dine with others. If you say they are, throw out the test; it's not so.

But when someone is singing our national anthem and I am alone, I stand and hold my hand over my heart, which you may find funny, but I don't, and I wonder how many others do it.

It distresses me, though, to see players and spectators on television, watching and listening to the musicians and the singer, and behaving indecorously. They are rude, they move about, they chat with others, they do not stand at attention, and they irritate me.

Then I get into the elevator and push the number one button to go down. And invariably, somebody gets in on another floor and turns all the way around to see if the ground floor button is lit, sees that it is, and to my astonishment, pushes it again. This is generally repeated on two or three more floors; each new rider turns to stare at the brightly lit number one button and then pushes it again, to be sure.

I don't mind, but I hope they stood at attention when they showed the flag.

F.C.

A DRUG PROBLEM WE CAN CURE

I will not consult my dictionary, lest it disagree with me; I know drugs is a bad word. It means anything we give the patient; but it also means marihuana, amphetamines, and cocaine. We speak of drug companies and the drug industry and of drug addicts in the same breath, but their meanings are worlds apart.

We record drugs on hospital charts, meaning digitalis and antibiotics; and we treat patients for drug habituation, meaning pot and speed.

We should stop this.

We list what are called controlled substances, but this sounds like controlled access highway; neither term rings a bell.

I suggest we stop saying drugs entirely. Say medicines or agents for the things we administer to our patients. Say something like dope for uppers and downers and hashish and horse.

Some things, like the opiates, belong to either group, but they are two entirely different clusters of substances, and their names have completely opposite connotations. To call all of these things drugs is confusing.

F.C.

ON SUICIDE

Approximately 940 people die per 100,000 each year in the United States, and 11.2 are suicides. Out of 1,921,000 deaths here in 1971, 22,630 were suicides. Each pair of numbers means that one of every 84.5 deaths was a suicide.

22,000 people take their own lives every year in the U.S., and if there are seven unsuccessful suicide attempts for every suicide (the estimate is 4 to 10), then 150,000 persons in this country try, successfully or not, to kill themselves each year.

I once counted all deaths of doctors for about a year, and I found that one in every 29 deaths was a suicide, which I interpreted to mean that one in every 29 doctors kills himself.

The suicide rate is probably lowest among pediatricians, and highest for psychiatrists, whose figure may be as much as six times as high as that of the baby doctors.

If my calculations are correct, the suicide rate is one in 84.5 deaths for the general population, and one in 29 for doctors. Of course, doctors are not the general population; we do not include children, and most physicians are male.

But one in 29 is much larger than one in 84.5. If my counting is significant, 3.44 percent of doctors' deaths are suicides, while only 1.18 percent of deaths in the U.S. are suicides.

And if we subtract doctors from the general population, we are left with something like 202,700,000 people and 22,500 suicides, so that only 1.11 percent of deaths in nondoctors are suicides. The suicide rate among doctors is thus more than three times that for everybody else.

F.C.

BRIEF NOTES FROM A MEETING

I am an inveterate note-taker, people-counter, and looker-upper, and this is what I jotted down during a recent medical gathering.

Every speaker says "I will be brief." This means "I will be long."

Many of the ladies were smoking cigarettes, and many of the men smoked, but the men have gone over to cigars. It is impossible to tell how many smokers surround you, because some who are not smoking at the time may have just put out a cigarette or will later light up. Anyway, doctors go right on smoking, and not taking their own advice.

All the speakers say "I would be remiss." This means "I will be long."

I was brief, wasn't I?

F.C.

Association of Cystic Fibrosis Factor to Metachromasia of Cultured Cystic-Fibrosis Fibroblast — B. S. Danes (Dept of Medicine, Cornell Univ Medical College, New York 10021). Lancet 2:765-767 (Oct 6) 1973.

An association between the presence of cystic fibrosis factor activity (CFFA) and metachromasia observed in some cultured cystic fibrosis (CF) fibroblasts was demonstrated through cell mixing. Correction of this mutant phenotype (metachromasia and presence of CFFA) occurred only if there was cell-to-cell contact, ie, metabolic cooperation with normal fibroblasts. No correction occurred if metachromatic, CFFA-positive CF fibroblasts were mixed with ametachromatic, CFFA-negative CF fibroblasts, thus supporting genetic heterogeneity within this clinically defined disorder.

Intermittent Mandatory Ventilation: New Approach to Weaning Patients From Mechanical Ventilators — J. B. Downs et al (Univ of Florida College of Medicine, Gainesville 32601). Chest 64:331-335 (Sept) 1973.

Some patients who have had their ventilation controlled are difficult to wean from mechanical to spontaneous ventilation. A new method of ventilatory support, intermittent mandatory ventilation (IMV), which allows the patient to breathe spontaneously as desired but also delivers hyperinflation at regular preset intervals, was used in over 50 patients. IMV is more efficient, safer, and more readily accepted by the patient.

Emergency Management of Esophageal Burns: A Review for the Primary Health Care Physician

LOUIS E. KLEAGER, M.D.*

and

C. T. YARINGTON, JR., M.D., F.A.C.S.†

ACCIDENTAL or purposeful ingestion of substances that are destructive to the esophagus will lead to further complications and sequelae which may be partially or wholly preventable by prompt diagnosis and institution of appropriate therapy. The goal of treatment is to salvage a functional esophagus through prevention of stricture, perforation and stenosis.

Immediate measures to be performed are:

1. Assure a reliable airway and take vital signs.
2. Determine the type of caustic ingested.
3. Give a bland neutralizing substance when indicated.
4. Complete an accurate history and physical.
5. Obtain a prompt esophagoscopy.
6. If esophagoscopy is not readily available, the patient should be started on steroids and appropriate antibiotics as soon as possible and then transferred to the appropriate facility for esophagoscopy. If no burn is found, then no further treatment is necessary, although the patient should be followed with an office visit in about two weeks.
7. If a burn is present, steroid and antibiotics should be started. The steroid of choice is methyl prednisolone succinate, 60 mg IM, which is then gradually tapered to maintenance doses of 20 mg IM every 10 to 12 hours until healing occurs. The antibiotics of choice are either penicillin or tetracycline, which should be continued for two weeks. As the patient stabilizes, serial esophagoscopy and dilatations are necessary if there is evidence of beginning stricture formation. When severe and extensive burns are found and coagulative necrosis is present, esophagogastrectomy may be indicated early in the course of therapy.

It is important to obtain a history that is as complete as possible, because the extent of burn is directly related to the amount and type of caustic ingested. For example, a large volume of liquid lye poisoning will be managed much differently than a chlorine bleach ingestion. If there is any doubt about the substance taken, it is best if a responsible party can bring the container or sample of the substance to the hospital.

Prompt esophagoscopy permits accurate diagnosis. It is imperative that all suspected of esophageal burns be directly examined as early as possible (i.e. within the first 24 hours) to determine the extent and the severity of burn. Optimum therapy is dependent upon this knowledge. If the treatment with steroids is to be successful in preventing strictures and stenosis, it should begin before scar formation starts, usually within the first 24 hours. If perforation exists, or where it is imminent, exploratory surgery may be necessary. One should not depend on the mother's history or the presence or absence of facial burns to diagnose esophageal damage. Chemical burns about the face and oral cavity may occur without any trauma to the esophagus, and conversely it is

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entirely possible to encounter an esophageal burn without visible insult to the oral pharynx.

Esophagoscopy done by experienced physicians is remarkably safe if care is taken to avoid contact with smaller burns, and if the esophagoscope is removed on reaching an area of circumferential burns.

Vomiting should be avoided. Gastric tubes should not be placed in the esophagus blindly. If needed, they should be placed by an experienced physician under direct vision with the esophagoscope.

Several classifications of esophageal burns have developed, but the most useful classification is based on the depth of the burn. In this respect one may see superficial, transmucosal, or full thickness burns, with or without perforation). SUPERFICIAL BURNS will appear hyperemic, without bleeding. Peristalsis is usually present, and there are no circumferential burns. TRANSMUCOSAL BURNS present with erosion of mucosa, bleeding, exudate, and frank ulceration. Later, the exudate is accompanied by pseudomembrane formation and granulation tissue. With the FULL THICKNESS BURNS the lumen may be obstructed by massive edema. Peristalsis and muscle tone are absent. Charring may be present. With time, there will be failure of mucosal generation leading to stricture formation and cicatrization.

The pathologic response with caustic ingestions is similar to that of chemical burns in other parts of the body. Following cell death from instant liquification necrosis, the lesion is surrounded by a cellular inflammatory infiltrate. In six or seven days, an ulcer or crater is formed when the necrotic tissue sluffs. A rich vascular bed of granulation tissue fills the base of the defect, and shortly thereafter epithelium (mucosa) begins to fill from the periphery toward the center. The esophageal wall is weakest at this point. Sensation and muscle function are permanently lost and will not regenerate. The scar tissue formed is directly proportional to the amount of granulation tissue, i.e. the number of active fibroblasts present in the lesion. Thus it is the attempt of steriod therapy to block the granulation tissue formation as soon as possible. Experimental studies with rats have demonstrated fibroplasia as early as 24 hours following caustic insult. In the same rats it was shown that steroids begun after 48 hours had very little effect in preventing scar formation.

Besides the size and depth of the wound, three other factors can promote granulation tissue formation:

1. Infection. Colonization of the crater occurs early and is a strong stimulant of granulation tissue formation.
2. Foreign body reaction. Food particles embedded in the wound are said by some to be strong stimulants for increased scarring.
3. Trauma. Passage of the food bolus with repeated stretching also stimulates fibroblastic activity.

During the second or third week following esophageal burns, swallowing often returns to "normal," leading to the false impression that the esophagus is healed. However, cicatrization has usually begun, and during the third to fourth week contractions and adhesions start to form. If serial esophagoscopy is performed, these scars can be identified, and treated by early dilatation, thus improving the chances of saving the esophagus. Dilatation is considerably less effective if it is started late in the course of the disease. In the patients who have not been followed by serial esophagoscopy, the first sign of contraction or stricture may be a slow change in the feeding habits.

Linear or streak burns rarely lead to stenosis. However, circumferential spiral or massive burns are quite prone to contracture formation and complete stenosis. These burns must be dilated early, and even then the esophagus may not be saved.

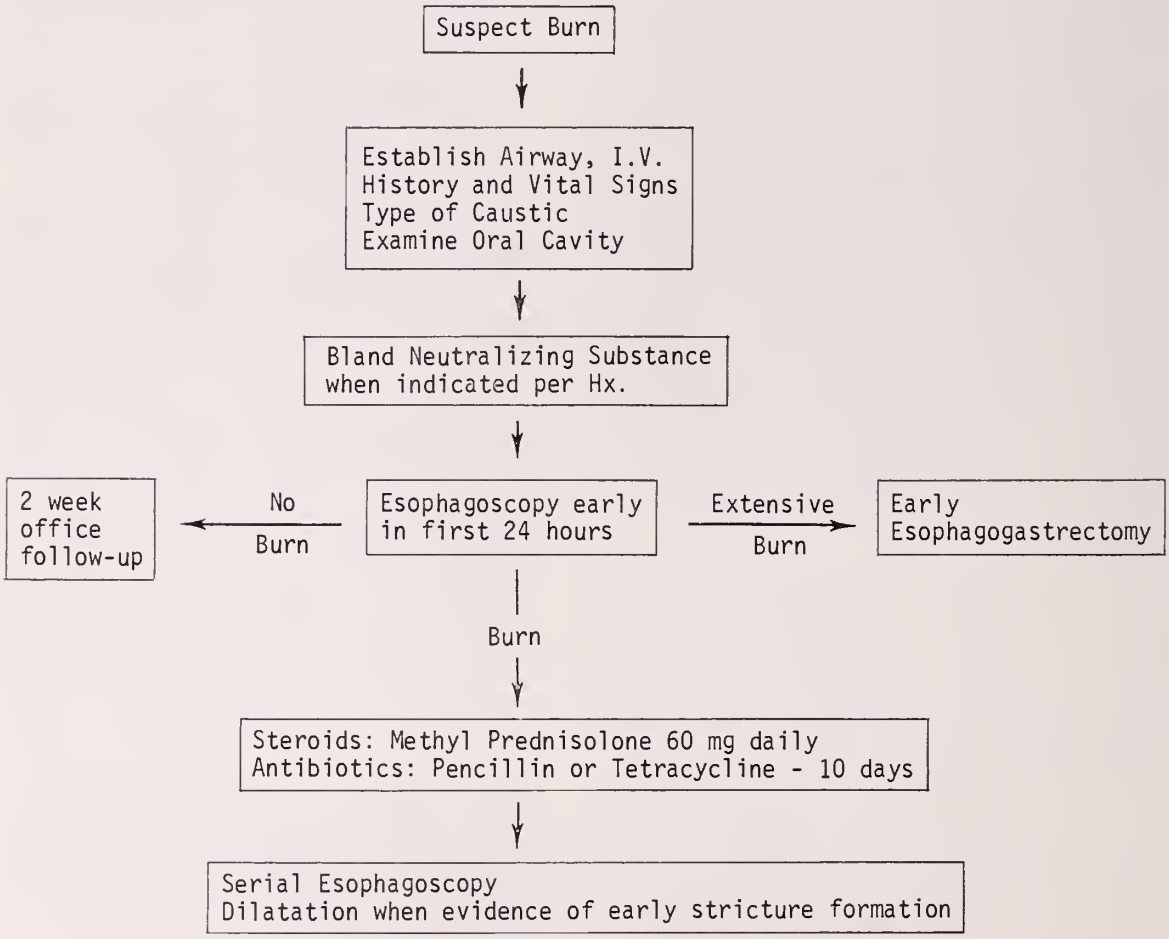
The particular caustic agents may be divided into several classifications. On a clinical basis, we can divide the caustics into two groups of severe, and extremely severe action. EXTREMELY SEVERE CAUSTICS, the most potent known, include liquid lye

preparations and concentrated acids. The most frequently encountered of these are the liquid lye drain cleaners. Liquid lye, marketed as Plunge and Liquid Plumr are strong (up to 52%) concentrations of sodium hydroxide. Extreme severity is due to penetrability, surface distribution, and the reaction of the stomach to the lye. Being in a liquid form, the lye rapidly spreads across the surface of the mucosa and penetrates the mucosal lining, causing rapid liquefaction necrosis. These agents are so corrosive that as little as half a teaspoon instilled in cats has been shown to cause rapid perforation of the esophagus and stomach, and death within 24 hours. One case has been reported in which a two year old girl developed complete esophageal stenosis from the residual lye in a Liquid Plumr cap that was thrown in the trash by her mother.

The reaction of the stomach and pharynx to liquid lye is rather interesting. X-ray

FLOW DIAGRAM FOR EMERGENCY

MANAGEMENT OF ESOPHAGEAL BURNS



NOTE: (1) Avoid vomiting.

(2) Avoid nasogastric tubes, except by placement by direct vision.

(3) If esophagoscopy is not immediately available, begin steroids and antibiotics while making arrangements for esophagoscopy.

studies of both dogs and cats have shown an "internal regurgitation" phenomenon after liquid lye ingestion. A quantity of liquid lye was injected into the esophagus of a number of dogs and cats. As the lye entered the stomach, the pylorus went into spasm, protecting the duodenum and allowing pooling in the stomach. Approximately 20 seconds after injection the stomach contents were violently regurgitated. However, when the lye reached the pharynx, the cricopharyngeus muscle immediately developed spasm, causing the lye to be returned to the stomach. This back and forth phenomenon occurred for approximately three minutes, burning the entire surface of the esophagus and much of the stomach. Twelve minutes following ingestion the pylorus relaxed allowing emptying into the duodenum. Some animals were found to have additional burns of the treachea and spleen from resulting perforations. Humans have much the same response; however, some will be noted to have vomited, and will be drooling on arrival at the local emergency room.

Strong acids may cause rapid lysis of the mucosa and perforation of the esophagus and stomach. Some series of patients show a 50% mortality rate, with severe stricture formation in those who survive. One case is reported with acid burns continuous from the oropharynx through the jejunum.

The SEVERE CAUSTICS included many compounds. Granular lye preparations (drain cleaners) usually cause linear, streaking, or punctate-patchy burns. The dry material is absorbed to the moist mucous membrane on surface contact and usually does not spread circumferentially around the esophagus. Multiple strictures may occur, but many times these injuries result in single streak strictures. These are less complicated to manage and oftentimes a functional esophagus can be salvaged.

Most of the granular caustics result in similar lesions, however, a word should be said about the nonphosphate detergents. Nonphosphate detergents are the newest corrosives marketed and have acquired increasing popularity as a so-called "ecological detergent." The several products which are marketed are all highly alkaline and contain a variety of active chemicals. Evidence is beginning to accumulate that these nonphosphate detergents are as toxic, or more so than the granular drain cleaners. Esophageal and gastric ulcers are reported by Lee following an injection of 10 ml of 30% solution by volume of nonphosphate detergents in cats. They also report the death of a 15 month old girl following a nonphosphate ingestion.

The type of patient most commonly presenting with suspected esophageal burns are children from ages 1 to 4 with a peak incidence of approximately 26 months. Accidental caustic ingestions taper off rapidly in age groups where the child begins to understand the danger of sampling common household products. This age is usually between 4 and 6.

Adult poisonings result from accidental ingestion (rarely) or from depressed psychotics who are making genuine suicide attempts. Suicide attempts by these means usually result in large amounts of caustic being ingested and generally necessitate prompt therapeutic surgery.

In summary, the ingestion of caustics should not be taken lightly. Treatment should begin immediately after diagnosis and not 3 weeks later when symptoms of esophageal stenosis begin to appear. The course of action includes stabilizing vital signs, an accurate account of types and quantities of substances ingested, and administration of appropriate neutralizing substances.

Diagnosis is made by direct vision with an esophagoscope, not by the mother's account of the accident. All suspected caustic ingestions should be esophagoscoped. Immediately following diagnosis, steroid and antibiotic therapy should be instituted. The drugs of choice are usually methyl prednisolone succinate, 60 mg IM every 12 hours, and penicillin or tetracycline. If prompt esophagoscopy is not available, it is recommended that the patient be started on steroids and antibiotics while arrangements for esophagoscopy are being made. Nasogastric tubes should not be placed in the esophagus, except by direct visualization.

Esophageal burns are a serious, and in

some cases, life threatening problem. If treated early and aggressively, the chances for esophageal salvage are improved. Nothing is more pitiful than a four year old child with a feeding gastrostomy undergoing serial dilatations, all of which might have been prevented by early aggressive treatment.

Health for the Public: Sickle Cell Program

HENRY D. SMITH, M.D., M.P.H.,*
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and
ROBERT S. GRANT, M.D., M.P.H.‡

FREQUENTLY, professional and lay people will inquire of health officials as to what constitutes an epidemic. The actual number of cases, which at times, may be large, is only relative depending on the population at risk. Often of far greater importance is the magnitude of the morbidity, physical, emotional, social, economic, etc. (and at times mortality) of a disease entity as it spreads through a population. Likewise, the prevalence and severity of a disease are key factors in determining its position of importance in the spectrum of public health problems.

During the past few years, sickle cell disease has received much publicity for a variety of reasons. Most important have been the discoveries in the molecular biology of hemoglobinopathies and subsequent development of fast, reliable, and inexpensive screening techniques. Paradoxically, these studies have revealed the etiology of the disease, but have not resulted in any highly acceptable form of therapy. Recent federal appropriations have increased public awareness to the problem.

It is the purpose of this paper to discuss a variety of approaches to identify and assist affected Nebraska residents in making well informed and educated decisions regarding their own sickle cell status, as well as their offspring's.

The term sickle cell disease includes sickle cell anemia, sickle cell trait, and sickle cell variants. It is one of the most prevalent genetic diseases, affecting 8% of the older black children and adults, and approximately 10% of younger black children. Of those who inherit the sickle cell hemoglobinopathy, approximately 1 in 400 to 500 will develop sickle cell anemia.

Sickle cell disease and other related hemoglobinopathies are the result of an anomaly in the molecular structure of the hemoglobin. The defect appears to arise out of an aminoacid substitution in the gene which controls synthesis of globin. The resultant abnormal hemoglobin, under stress conditions, primarily reduces oxygen levels in the blood, causes sickling. Sickle cells have a tendency to agglutinate and are more susceptible to disintegration and phagocytosis. With significant reduction in cells, an anemia can result. The anemia, which varies in degrees, and at times may be quite severe, often is frequently well tolerated.

Clinical manifestations result mainly from a vasoocclusive process. The decreased solubility of HbS, under reduced oxygen conditions, results in long crystal-like structures that distort the shape of the red cells. Sickled cells are rigid, and if predominant, will cause blood to be more viscid and flow less readily through blood vessels. Pain, sometimes accompanied by fever, is the most dramatic symptom as the small capillaries become occluded.

There may be involvement of the spleen, kidneys, lungs, and other organs through

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infarction; ulcers of skin may develop in some cases. Cirrhosis of the liver and bone marrow changes are other eventualities. Strokes and blindness may occur from involvement of the central nervous system. Height and weight may be below normal for age, and delayed sexual maturation and reduced fertility are frequently seen.

Sickle cell disease is found predominantly in the black race, but occasionally is seen in other racial groups of Mediterranean origin. The mutant gene offers some degree of protection against malaria. The gene is recessive and transmitted in accordance with Mendelian law. The trait is the heterozygous state, and sickle cell anemia the homozygous state. Therefore, when both parents contribute a defective gene, the anemia will be passed on. However if one defective gene is received, an offspring will have the trait. When only one of the parents has the disease or the trait, a child will not have the anemia, but may have the trait. If both parents have the trait, the chances are one in four that a child will have the disease, two in four he will have the trait, and one in four he will not have the anemia or trait.

Mass sickle cell screening programs and screening legislation have been proposed by many groups. The effects, unfortunately, have been near chaotic in some situations, resulting in denial or dismissal of employment, in addition to the personal anxiety produced. Investigation has revealed there has been a lack of sufficient education and counseling efforts, since the major emphasis has been on testing, and in some programs, without confirmatory tests.

The present philosophy of the Nebraska State Health Department has been to emphasize revised traditional activities found at that level and developing health services utilizing a pleuralistic health delivery system. The approach has been a holistic one, encompassing comprehensiveness of health services to the individual, the family, communities and the entire State.

The Nebraska State Health Department attempted to ascertain the magnitude of the sickle cell disease problem within the state and possible resources available to underwrite a program. Factors to be considered were the number of residents who might be at risk, and the number already screened through other sources. As of January 1972, limited funding was obtained; other resources (in Omaha) included clinical services at two medical schools, Children and Youth, Maternal and Infant Care Programs and an active city-county outpatient service. Of some concern was the fact that no organized educational program or counseling service for those at risk was established. This is not to imply that patients and their families with sickle cell anemia were not receiving excellent medical attention and counselling. Numerous instances were cited of services available at the hematology clinics operated by both medical schools and a number of private hematologists. Nevertheless, black residents without an immediate family member with sickle cell anemia had little opportunity to familiarize themselves with the disease. Unfortunately also, was the lack of routine screening of black patients in clinic facilities.

In Lincoln and outstate Nebraska, services were available on a one to one basis. Only physicians with patients having sickle cell anemia offered complete testing and counseling of patients and their families. The majority of physicians rarely obtained either a screening examination or electrophoretic pattern on their black patients. No educational programs were noted.

The black population in the State of Nebraska is concentrated in the city of Omaha. 34,722 reside in the Omaha-Douglas County Area, 2,432 in the Lincoln area, and 2,757 throughout the remainder of the State. (See map). Discussions with many black residents throughout the State revealed their awareness of the problem and need for a comprehensive screening program.

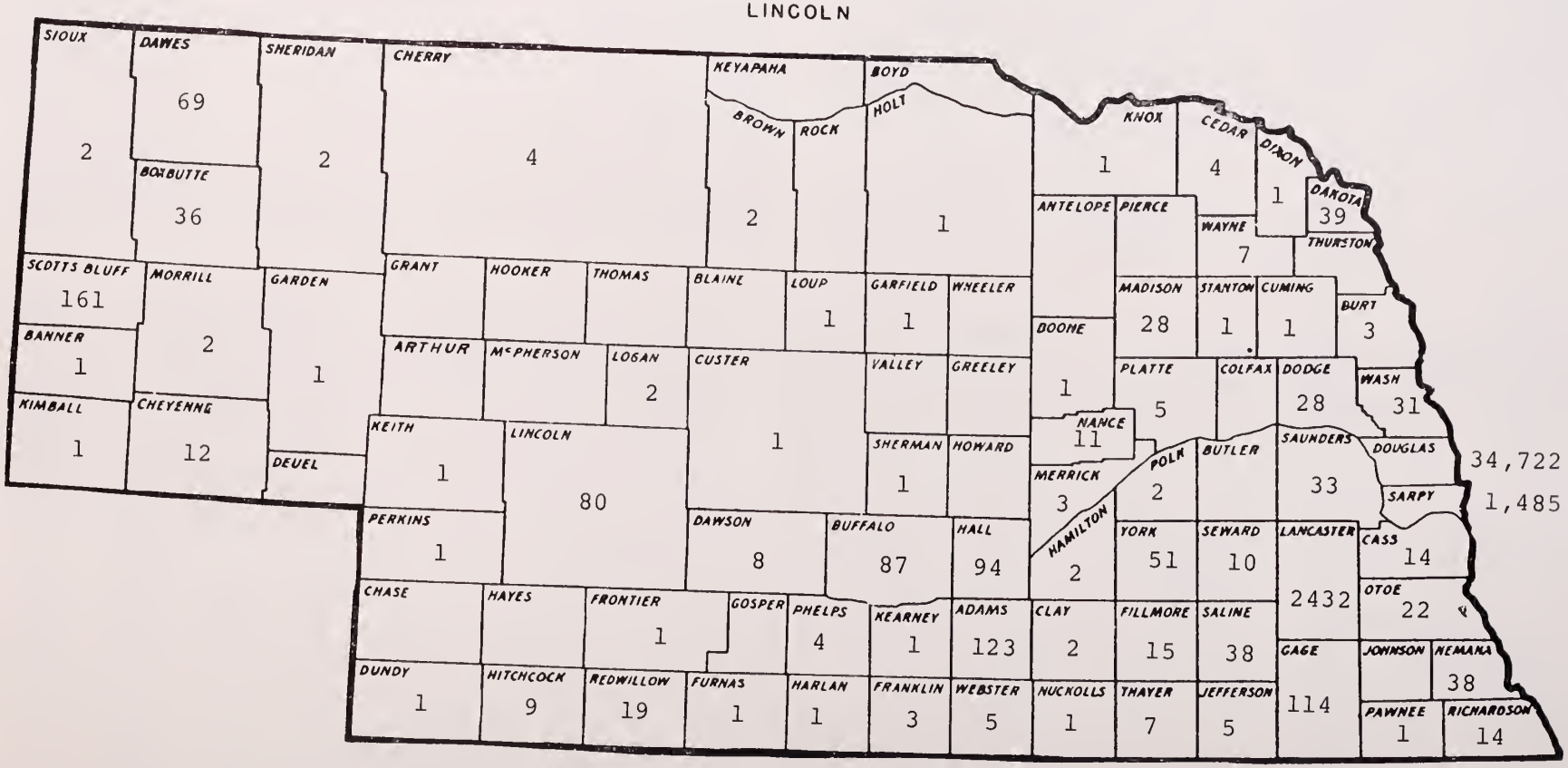
The State Health Department initiated a series of conferences with health officials in Omaha, Lincoln, and the statewide family planning centers. A three-phase program was outlined with the initial program to be held in Omaha, followed by a similar program in Lincoln. The third phase was to be conducted with the assistance of the

NEBRASKA NEGRO POPULATION
BY COUNTY
1970 CENSUS

STATE OF NEBRASKA

DEPARTMENT OF HEALTH

LINCOLN



Total Negro Population 39,911

outstate physicians, utilizing the network of the Nebraska State Family Planning Centers as educational and counseling sites if necessary.

The Omaha portion of the program was started with the selection of an advisory committee. Numerous invitations were sent to persons or groups who would be interested. No attempt was made to limit the size of the attendance at the first meeting. Maximum attempts were made to secure representation from a number of black organizations. The advisory committee, when finally constituted, consisted of the director of the Omaha - Douglas County Health Department, representatives from the Omaha Public School System, the Genetics Division of the University of Nebraska Medical Center and the Comprehensive Health Association of Omaha. The State Director of Maternal and Child Health Division maintained a liaison role between the advisory committee and State Health Department.

The committee recommended strong involvement of the black community in decision making concerning the program. Also recommended, depending upon availability of funds, was a complete program, with the major emphasis on education, counseling and identifying resources for additional testing and treatment. The committee considered the possibility of a mass testing program and reviewed the results of such efforts in other communities. It was noted that participation as a rule did not meet expectation and follow-up counseling efforts were limited and inadequate because of the logistics involved. It was felt that a testing program, to be of value, would best be directed towards the adolescent and child-bearing age, but that all elements of the program would be available to the entire community on a voluntary basis. It was agreed to begin testing in schools with a large black population. Hopefully, though not completely valid, the "index" case of the trait or the anemia could be ascertained in that selective group. With complete follow-up and personalized counseling, a maximum number of the designated population could be reached.

The black community was involved both directly and indirectly in the above suggestions. The Comprehensive Health Association of Omaha which was established to originate and coordinate health services on the north side of the city is predominantly black. The director was elected chairman of the advisory committee.

The advisory committee members became part of a multidisciplinary team. Assignments were as follows: Comprehensive Health Association of Omaha took responsibility for lay education and publicity; the Omaha-Douglas County Health Department provided the specimen collecting teams and performed the laboratory examinations; the Department of Public Health Nursing provided the follow-up and counseling for those found to be positive for the trait or anemia. The assistant superintendent of schools and head school nurse coordinated the program into the school system and sent out permission requests and program information. Overall coordination was under the City-County Maternal and Child Health and Health Education Division.

Numerous public service spot announcements were placed on television, radio, and in newspapers. Education and information concerning sickle cell disease was directed toward both the black and white populations, with greater emphasis on the former. The nurses were instructed by seminars and a special inservice training program by the Genetics Division of the University of Nebraska Medical Center.

The Sickledex Test(TM) was used as a screening test and confirmatory testing was done by electrophoresis. During the month of May, 1972 — 6,455 school children were tested in 27 schools of the Omaha Public School System, as shown in the following table:

Schools	Total Tested	Percent of Total Tested
Elementary Schools	5,175	83%
Junior High Schools	946	62%
Senior High Schools	334	36%
Total	6,455	75%

402 children had sickle cell traits and there was one case of previously undetected sickle

Rx Sports & Travel Publisher to Speak at NMA Luncheon Tuesday, April 30

The publisher of the first leisure magazine for physicians headlines the NMA Luncheon April 30th.

James D. Telfer, M.D., of Hillsboro, Illinois, is a family practitioner. His varied background includes instigation of the U.S. Medical Open Golf Tournament. He served as Captain of the U.S. Medical Golf team in 1972 and 1973. He is the first foreign member of the British Medical Golfing Society. Dr. Telfer has been a radiation geneticist, served as the first Director of the USAF Space Biology Laboratory and worked in biophysical research at Medical College of Virginia. He received his degree from the University of Louisville in 1958.

Dr. Telfer is Past President of the Montgomery County Medical Society and Montgomery County Board of Health. He is Past Director of the Illinois Academy of Family Practice and former Chief of Staff, Hillsboro Hospital. He is a member and Past President of the Hillsboro Board of Education.

cell disease. All parents were notified by mail and an identification card was enclosed explaining whether the child had the trait or the anemia. Following this, four specially trained public health nurses did a follow-up by telephone calls and home visits. Parents were receptive to the home visits and genetic counseling. The follow-up visits also discovered the following:

1. 47 families had other health problems for which they needed medical supervision and were referred to appropriate sources.
2. 31 families had a history of sickle cell anemia or trait in their family.
3. 108 families had numerous other family members who had never been screened.
4. 128 families expressed interest in a foundation or organization for sickle cell families. This included a desire for further knowledge, group work, etc.
5. Reception was extremely good except in two instances where it was intimated that the purpose of the program was genocide, and that the disease was the creation of whites to eliminate blacks. A number expressed regret that more was not being done.
6. Staff found numerous family members were interested in, and participated in the program.

Subsequent publications in this journal will describe the sickle cell programs in Lincoln, and a statewide program.

Physicians or other groups desiring literature or other assistance regarding sickle cell disease should contact:

Dr. Henry D. Smith
Director of Health
Nebraska State Department of Health
Lincoln Building
1003 "O" Street
Lincoln, Nebraska 68508

This program funded by Title V Maternal and Child Health.

Harkavy's Syndrome

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and
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Omaha Veterans Administration Hospital
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IN 1941, Joseph Harkavy[1] reported eight patients with manifestations of (a) bronchial asthma, (b) extensive peripheral eosinophilia, and (c) the involvement of the serous membranes, in particular, pleural effusion. He considered these cases to represent a hypersensitivity response of various organs involving primarily the blood vessels.[2] In a larger prospect, this syndrome occupies a transitional stage between relatively benign Loffler's syndrome in one hand and destructive periarteritis nodosa in the other extreme. Because of a relatively rare incidence of this syndrome its prognosis has been rather poorly understood. We report here one case of Harkavy's syndrome which has been well managed with a small dose of steroids for over a four year period.

Case Report

Present Illness: The patient is a 52-year-old white male who entered the Omaha Veterans Administration Hospital in September 1968 because of muscular aches, pleural effusion, wheezing, and peripheral eosinophilia of 70%. He has had bronchial asthma since 1962, which has become progressively worse. At the time of admission, the asthma attacks occurred approximately one to two times per week. In May 1968, he had a severe muscular ache in both upper arms and across the shoulders. It was treated with phenylbutazone. On admission he was also found to have bilateral pleural effusion and leukocytosis of 17,000/cu mm among which 70% were eosinophils. The patient produced approximately 4 oz per day of clear white stringy sputum mostly in the morning. He had been afebrile.

Past History: The patient had been in excellent health until ten years ago when he began to wheeze. Because of wheezing, he had a course of desensitization treatment, from 1962 to 1965. He never smoked and drinks only on social occasions. There is no history of exposure to dust or chemical fumes. He has been an undertaker. No history of trauma or surgery. Patient's father had asthma, and nearly all his relatives on the paternal side had asthma. An uncle died of leukemia and a cousin died of "purpura."

Physical Examination: Patient is a well developed, well nourished white male with apparent wheezing at rest. Weight, 146 lb; height, 5 ft 10 in; blood pressure, 120/80 mmHg, supine, left arm; respiration, 28 per minute; pulse, 100 per minute; afebrile. HEENT: unremarkable. Lungs: expiratory wheezes bilaterally and decreased resonance to percussion at both bases. No rales were heard. Heart: regular sinus rhythm without murmur. Liver: palpable 2 cm below right costal margin and not tender. Spleen and kidney: not palpable and no mass in the abdomen. Extremities: no ankle edema, clubbing, or cyanosis.

Hospital course and laboratory data: The chest x-ray on admission revealed extensive bilateral pleural effusion with consolidation of the right lower lobe. The heart and the great vessels were normal. (Figure 1). Skin tests for mumps, pulmonary tuberculosis, histoplasmosis, and coccidiomycosis were all negative. The skin test for trichinella was negative. The EKG showed normal electrical axis and sinus rhythm at a rate of 60 per minute. The PR interval was 0.17 sec, and the QRS interval was 0.08 sec. The following laboratory studies were all normal: serum electrolytes, urinalysis, glucose tol-

erance test, LDH, SGOT, SGPT, CPK, BUN, serum creatinine, and uric acid. The stool examinations for ova and parasites were negative, and the Coombs test (direct and indirect), VDRL, RA factor, and LE preps (3x) were also negative. The first thoracentesis was done on September 20, 1968. This revealed serous fluid with specific gravity 1.034, glucose 98 mg%, cell count 2,400/cu mm among which were 58% eosinophils, protein 5.5 gm%, LDH 217 mu/ml, SGOT 13.6 mu/ml, and SGPT 5.6 mu/ml. The culture of pleural fluid grew no bacteria. The CBC on September 24 showed the leukocyte count to be 12,300/cu mm, among which were 52% eosinophils, 33% neutrophils, and 11% lymphocytes. Steroid treatment was initiated on September 25, and two days later the leukocyte count was 11,500/cu mm with 10% eosinophils, 68% neutrophils, and 19% lymphocytes. Within two weeks following steroid treatment the leukocyte count was 6,100/cu mm with 7% eosinophils, 51% neutrophils, and 31% lymphocytes. Steroid treatment was discontinued after three weeks. Three days later the leukocyte count was 7,300/cu mm with 40% eosinophils, 25% neutrophils, and 28% lymphocytes.

A second thoracentesis was done on September 26. The fluid showed a specific gravity of 1.035 and a cell count of 2,100/cu mm with 58% eosinophils. Glucose in the pleural fluid was 172 mg% and the total protein was 5.5 gm%. There were no malignant cells in the cell block. The first bone marrow biopsy done on October 1, 1968 showed marked eosinophilia. The second bone marrow biopsy obtained on October 22 again showed eosinophilia without evidence of primary proliferative disease. The iron stores were adequate. A pleural biopsy revealed pleuritis of a nonspecific chronic type. The serum protein electrophoresis showed albumin 2.68 gm%, alpha 1 globulin 0.13 gm%, alpha 2 globulin 0.33 gm%, beta globulin 0.39 gm%, and gamma globulin 1.96 gm%. The lung function tests revealed a vital capacity (VC) of 4.300 L, and a residual volume (RV) of 2.455 L, with a total lung capacity (TLC) of 6.755 L. The one second forced expiratory volume ($FEV_{1.0}$) was 65.0%, and the maximum voluntary ventilation (MVV) was 98.9 L/min. The muscle and skin biopsies of the right deltoid region were essentially normal.

The pleural effusion gradually sub-

Figure 1

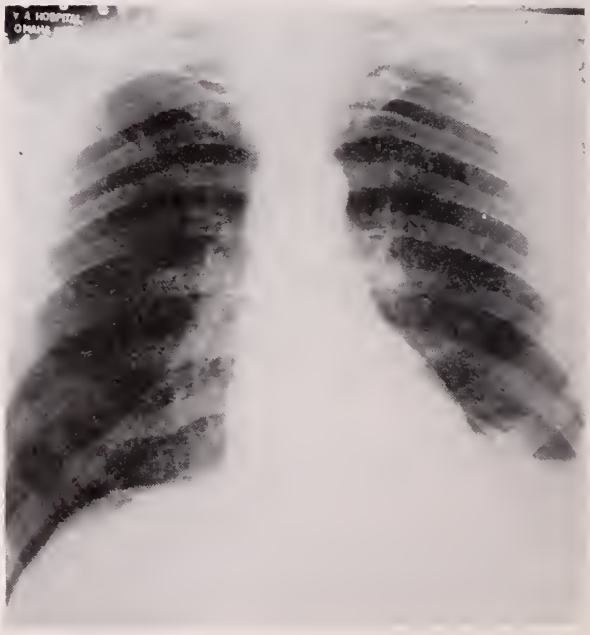

Figure 2

sided with steroid treatment. The first to clear was the right lung and subsequently pleural fluid completely cleared. (Figure 2). The patient was discharged on October 25, 1968 with a small dosage of prednisone (10 mg per day).

On November 16, 1970, he was readmitted to Omaha VA Hospital for a follow-up study. The CBC showed hemoglobin 15.0 gm%, hematocrit 45%, WBC 7,500/cu mm, 1% eosinophils, 58% neutrophils, 36% lymphocytes, 4% monocytes, and 1% basophils. The RA factor and LE prep were again negative. The second lung function test was performed on November 17, 1970. This indicated slight improvement in the $FEV_{1.0}$ and the MVV. The VC and the lung volumes were essentially unchanged. He was dismissed after two days with a regimen of 10 mg prednisone per day.

Follow-up Study: In May 1971, the dosage of prednisone was reduced to 7.5 mg per day because of no sign of wheezing, pleural effusion, or eosinophilia. The CBC on May 17, 1971 revealed Hb 14.4 mg%, Hct. 46%, WBC 9,600/cu mm, 0% eosinophils, 54% neutrophils, 44% lymphocytes, and 2% monocytes. In September 1971, the prednisone was reduced further to 5 mg per day and the patient continued to do well. His chest x-ray films were essentially normal. (Figure 3). Therefore, in November 1971, the prednisone was discontinued. In January 1972, however, the CBC revealed a return of eosinophilia (10%) although clinically he had no signs of wheezing or pleural effusion. The patient was given 2.5 mg of prednisone per day. In August 1972, the CBC showed WBC 6,700/cu mm, RBC 5.02 million/cu mm, and 8% eosinophils. Therefore, the prednisone was increased to 5.0 mg per day. It appears that the patient needs long term use of steroids to control the eosinophilia.

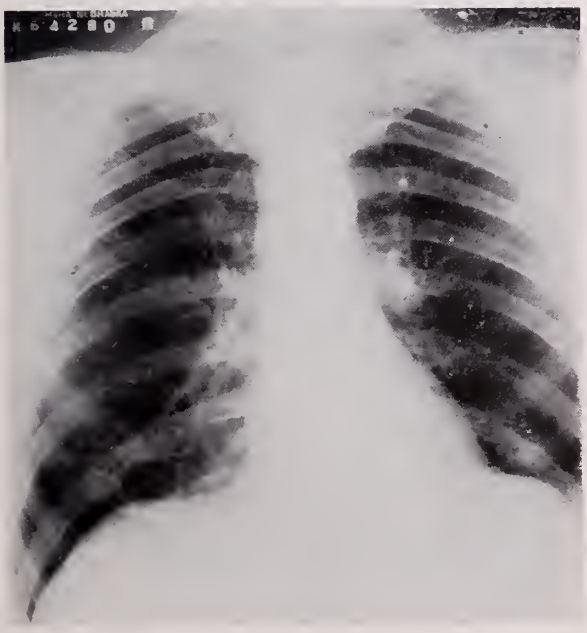

Figure 3

Discussion

Since the original description of Harkavy's syndrome in 1941,[1] several cases have been reported in the literature. These are rather few in number and provide a varied spectrum of the natural history and prognosis. A classical paper by Crofton et al[3] on pulmonary eosinophilia describes two cases of Harkavy's syndrome; the first case (Case No. 11) is a 21-year-old female patient who was admitted to a hospital in 1942 with asthma, left pleural effusion, and eosinophilia of 93%. A year later she developed bilateral hydrothorax, fever, leucocytosis, and eosinophilia which varied between 12 to 44%. Her hydrothorax gradually subsided following repeated aspiration and she became asymptomatic with a return to normal blood counts. Meanwhile, painless nodules developed in her forearm and palm. Biopsy of these nodules showed granulomatous change without evidence of periarteritis nodosa. She remained well, apart from occasional wheezing, until 1952 when she was readmitted to a hospital with cardiac failure and bilateral pneumonia. This case represents a span of 10 years of follow-up since the first onset of Harkavy's syndrome. The second case (Case No. 12) was a 45-year-old female patient who was admitted to a hospital in July 1945 with right pleural effusion, ascites, asthma, and eosinophilia of 77%. During the next year she had

persistent bronchospasm but slowly improved. The pleural effusion cleared finally. Biopsies of muscle and lymph nodes were negative and no arterial lesions were found.

The paper by Reeder and Goodrich[4] on pulmonary infiltration and eosinophilia (PIE syndrome) contains no cases of Harkavy's syndrome. All four cases reported by the authors had eosinophilia and/or asthma, but no pleural effusion. The recent paper by Hardy and Anderson[5] on hypereosinophilic syndromes reports 1 case (Case No. 3) which may be considered to be Harkavy's syndrome. This is a 43-year-old postal employee who began to wheeze with chest congestion and was found to have eosinophilia ranging from 73 to 88% with cardiomegaly and minimal right pleural effusion. Lately, Carrington and his associates[6] reported a distinct form of eosinophilic pneumonia which is a relatively chronic form lasting from a few months to several years, limited to females, with asthma in the majority and various pulmonary infiltration. None of the 9 cases reported by these authors had pleural effusion. In these cases the use of corticosteroid therapy was effective in clearing pulmonary infiltrates and symptoms. The prognosis of this chronic eosinophilic pneumonia was considered to be good by the authors.

Among the eight patients originally described by Harkavy[1] there were two deaths, two unimproved cases, and four patients who were "doing well." The treatments available at that time however were limited to desensitization, change of climate, and sinus operations. The steroid therapy as presently used in the treatment of allergic conditions was not available at that time. Therefore, the prognosis described in the above cannot be compared directly with that observed in the present era of steroid therapy. A favorable response to steroid therapy was recently reported by Rubin and Siegelman[7] in a 37-year-old male patient with Harkavy's syndrome. The duration of treatment and improvement was not clearly specified.

Although the mechanisms of eosinophilia still remain largely unknown, there is an increasing amount of data which suggests that the eosinophilia is mediated through the immune processes.[8] Boyer and his associates[9] divide the stage of eosinophilia into inductive and proliferative phases. During the inductive phase which lasts for about 24 hours, the lymphocytes seem to be acting principally, while the proliferative phase is sensitive to immunosuppressive drugs such as methotrexate and cyclophosphamide. It would be interesting to study the effect of immunosuppressive drugs in Harkavy's Syndrome with or without the steroid therapy as currently practiced in the treatment of hypersensitivity disease.

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Current Status of PSRO

ROBERT D. HUNTER, M.D.
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ANY consideration of PSRO must begin with a touch of history, history of a recent past. Organized medicine has always been supportive of peer review dating from the first tissue committees and records review committees of hospital staffs, perhaps best exemplified by the activities of the JCAH, peer review by outside physicians and subjection to comparison with standards created by physicians.

In its first medicredit bill the AMA opted for inclusion of PRO. In its second presentation this was omitted because of the possibility or probability of national standards, guidelines, and possibly fee schedules. There was also confusion that inclusion of PRO suggested quasi endorsement of PSRO, an entirely different ball game.

In any event, as of October, 1972, PSRO by inclusion in H.R. I became the law of the land. The Board of Trustees was not completely surprised that this occurred and was prepared to present to the House of Delegates in Cincinnati, the following month, report Z, which was adopted without serious dissent. Adoption of this report mandated a "leadership role" for the AMA, to be carried out by the Board of Trustees.

In consequence an Advisory Committee was formulated and called into session in January, 1973. This committee was chaired by a member of the Board of Trustees and included representation as well from the House of Delegates, Council on Medical Services, Council on Medical Education, the Inter-Specialty Council, Council on Legislation, Intern and Resident Section. Other organizations have a direct involvement in and a concern with PSRO, so invitations were extended to and accepted by the American Hospital Association, Blue Cross, Blue Shield, Health Insurance Council, American Dental Association, American Nurses Association, National Medical Association, Nursing Home Association, and American Association of Foundations for Medical Care.

The first concerted act of this committee was to ask for a moratorium on all grant applications and formalized structures of PSRO's until: (1) A National Director had been named, (2) An Advisory Council to the Director had been formed, and (3) Some feedback had been obtained relative to models, rules, structure, areas, and guidelines of care.

The second action of the committee was to appoint task forces, drawing on the expertise of the nation, to study and report back on each of these subjects, plus a task force to address itself to education of and communication with the membership, plus a final evaluation task force to survey the over-all effort and suggest discharge of the Advisory Committee.

Each of these task forces has met and has reported to the full committee, on April 14, from which the information was summarized and presented to the Board of Trustees for further direction.

In the interim, Doctor Charles Edwards has been named Assistant Secretary of Health, Doctor William Bauer of Greeley, Colorado, has been named Director of PSRO, with William Connors of Wilmington, Del., as his Administrative Assistant. Doctor Dale Schumaker has served as interim Director prior to Doctor Bauer's appointment and has been most cooperative and helpful to the Advisory Committee.

Some general suggestions from the first reports of the task forces include suggestions that we must indeed make haste slowly and maintain a close alliance with existing medical organizations. Uniformity of data collection and processing is imperative, and a task force to this end has been added.

National standards of care and review must be very broad-based, with considerable latitude for local adoption.

Of equal priority and concern in all PSRO activities must be a corresponding and proportionate inclusion of quality considerations.

Emphasis is given to the utilization wherever possible of existing review organizations with a history of success. A point of emphasis is an ongoing review and evaluation of the review organizations.

The single solid recommendation of the task force on area designation is that these should not cross state boundaries, with very rare exception.

The task force on norms has had a running start on their subject matter, thanks to the Inter-Specialty Council activities. The norms of care will apply to 75% of the most common diagnoses. They must be adapted to computers. They must be programmed to allow for change. Cost savings can not be of high priority as no one can insure that the total PSRO will lead to either dollar savings or dollar recovery.

The time table for the establishment of norms is included.

The task force on communication and education has several excellent recommendations: first, that there be state counterparts of our National Advisory Committee with a two-way flow of information, perhaps implemented best with a regular news letter. Basic information could perhaps be communicated through a slide talk and lay education could perhaps be best implemented with the preparation of a film prepared at the AMA.

The language and the intent of this legislation is to give the medical profession the opportunity to provide to a third party payor, in this instance the Federal Government, assurance that for 38% of the population, including medicare, medicaid, and rehabilitation services to children recipients, the payor is getting his money's worth. Evaluation embraces the necessity of service, the quality of care, and the over-all cost.

This is a tremendous charge which will embrace 11 million hospital admissions per year, with that number increasing yearly. This demands establishment of parameters of diagnoses and care and length of stay, with "review" of all deviations, and likewise mandates the rotation of all providers in a given area through the review process, all of this to be accomplished by newly created, non dues-paying organizations including all providers of services in a given area.

The attitude at this point in time of the AMA is one of complete pragmatism. Senator Bennett on at least two occasions has stated that flexibility is a byword in the implementation of this legislation. In response to a survey by the AMA, 36 states indicated their desire to form a single statewide PSRO. These range from states with fewer than 300 M.D.'s, to states with several thousand. The attitude which currently prevails and is shared by Doctors Edwards and Bauer, is that which works is acceptable and desirable. Certainly the same rules can not apply to our largest state with the smallest number of physicians, namely Alaska, and to Massachusetts, with the greatest physician-patient density of any state in the union.

The Social Security Administration will most likely be given the task of developing mechanisms for data accumulation. Their experience under Medicare will be the basis of this assignment. HSMHA, on the other hand, will probably have the task of developing the norm for quality evaluation. Projects and experiments in peer review and a closer relationship to medical practice will dictate that assignment.

Some states are advanced far beyond others in their preparation and developments. As a result, some of the problems and difficulties of implementation are already becoming apparent. These include: (1) Zealot resistance, a refusal to be involved or to cooperate, feeling that the whole thing is a subversive plot; (2) Geographic resistance, the doctors of X locale do not want to be evaluated by doctors of Y area, or city or school; (3) The perpetuation of "incestuous review," that is in medical schools, large hospital staffs and foundations or other prepaid plans; (4) A larger problem encountered is the apparent overlooking of the role of state government and state agencies as providers of medicaid funds and in many

instances service as fiscal agent for the programs included. No new program of this magnitude could be launched without problems. Problems are meant to be solved. There is a corresponding demand for leadership and our profession must supply this leadership, from the grass roots to 535 North Dearborn, and from 535 North Dearborn to the grass roots. There is a tremendous need for education and communication.

PSRO legislation can be viewed as a challenge and an opportunity fully as much as it might be labeled "Doomsday Arrived."

If this law of the land leads to failure, if it is impossible of fulfillment, let it be because it was poorly designed and impossible of accomplishment, not because we failed to pick up the gauntlet and not because we failed to give of our time and energy to the best and fullest of our capability.

Summary of Presentation

WAYNE W. BRADLEY
Assistant Director
AMA Washington Office

THE principle health laws passed in the last Congress were the Comprehensive Health Manpower Training Act of 1971 which extended and expanded medical education grants and student loan programs; the National Cancer Act which expanded the National Cancer Institute role; the National Heart, Blood Vessel, Lung and Blood Act of 1972 which accelerated federal effort in this other major disease area; the Uniform Services Health Professions Revitalization Act which authorized an Armed Forces medical school; and the Social Security Amendments of 1972 which had a host of Social Security, Medicare and Medicaid amendments including PSRO.

Two major pieces of legislation which were not enacted into law in the 92nd Congress were the Fiscal Year 73 Appropriations Bill for HEW and Health Maintenance Organization Assistance.

In the 93rd Congress the major legislative activities will fall in two areas:

HMO Assistance
Extension of existing public health service programs.

The Senate Committee has cleared a $1.5 billion HMO bill for Senate floor action. This represents a partial victory for fiscal sanity since the Senate bill last year called for $5.2 billion in HMO subsidies. A further-reduced HMO bill, authorizing $805 million over a three-year period passed the Senate 69-25 May 15, 1973. Both Nebraska Senators voted no.

In the House the Health Subcommittee had a number of sessions trying to reach agreement on a bill. To date they have made several modifications in the bill which the Subcommittee wrote last year after several months of consideration. The Health Subcommittee subsequently reported a bill to the full Committee which was scheduled to consider the legislation in June. The House bill in general has a more modest approach, calling for a limit of 100 federally-subsidized HMO's including any which result from current experimental projects funded under HEW discretionary authority.

AMA's position on HMO legislation has been consistent since bills were proposed early in the last Congress. The AMA supports prepaid group practice as part of a health delivery system which encourages competing forms of care in order to produce the most effective system for the patients. The AMA supports HEW's experiments with HMO's. AMA opposes an open-ended commitment to HMO's such as called for in the Senate's HMO Bill (S. 14) and believes there is hazard in any delivery system dependent on long-term, if not permanent, federal subsidy in order to exist.

The other major activity — extension of expiring public health service programs — has already occupied some weeks of the Health Subcommittees attention and will undoubtedly take many, many more weeks in this Congress before it is resolved. Since almost all the public health service programs expire at the end of this fiscal year (June 30, 1973), the Congress is under some pressure to act on these programs. Yet they consist of a wide range of programs which will require extensive hearings and consideration because they affect the whole thrust of the health activities of the Federal Government. The programs expiring include health services research and development, health statistics, public health training, migrant health, comprehensive health planning, Hill-Burton programs, allied health training, regional medical programs, population research and family planning, developmental disabilities, medical libraries and community mental health centers.

Because the Administration was restudying these health programs and subsequently recommended that some be terminated and others combined, the Congress was unable to have meaningful consideration until after the Administration made its decisions. As a result a one-year extension of the expiring programs was passed by the Senate, 72-19, in late March. Undoubtedly the House will take the same action, but the Administration has indicated that such action would be vetoed. As time marches on toward the June 30 deadline, however, some agreement will have to be worked out since there just is not enough time left now for the House and Senate Health Subcommittees, their parent committees, the full House and Senate and the Conference Committees (when necessary) to work out details of over one dozen programs and send them to the White House.

Tied into this issue of the expiring health programs is the Administration's determination to invoke stringent controls on the budget in order to reduce the multi-billion dollar deficits of recent years. In their efforts to reduce federal spending, the Administration has been bolstered by a significant number of freshmen Congressmen, both Republican and Democrats. Some 55 first-term Members of the House earlier this year pledged a "united front in behalf of a firm ceiling on federal expenditures and a return to fiscal responsibility." This assertion of and position by the freshmen Congressmen is unusual, but it is typical of the stronger voice that freshmen are seeking in the affairs of Congress. In recent years we have seen a generally younger group of Members entering Congress, men and women who are less interested in secrecy and seniority and more interested in action. They are not necessarily more liberal but they do want an effective Federal Government and in most cases a Federal Government in partnership with state and local government.

Medicine must be responsive to these demands. We must continue to offer constructive suggestions at the same time we oppose legislation that is not in the interest of the physicians or the patient. If we fail to offer our own ideas we will be reacting solely to someone else's ideas. In the field of health it is essential that the professionals — the physicians of this country — continue to offer their ideas and their leadership.

Fifty Years in Medicine

ARTHUR C. ANTONY, M.D.

WAS graduated from Creighton University Medical School in 1924 at age 22, completed internship at St. Joseph's Hospital in Omaha, Nebraska in 1925. His first practice was in Cuba, Kansas for one year, after which he moved to Clyde, Kansas where he was a General Practitioner until 1951, except for one year spent in Philadelphia, Pennsylvania at the University of Pennsylvania in Post Graduate work in Surgery, and a short stint in the Army during World War II.

Dr. Antony was the typical Country Doctor. Many is the time that he plowed mud in the rural areas to reach a patient. Sometimes his car wouldn't make it through the mud and snow and a friendly farmer would hook up a team of horses to an open wagon and take him across the fields to reach the patient. Up all night with a sick patient or an expectant mother, on many occasions. Since the nearest hospital was 14 miles away from Clyde, he delivered many babies right in the home. He said that during the depression he didn't make much money but he must have been the best fed Doctor in the Country as many of his patients paid him with chickens, eggs, sides of beef, etc.

In 1951, partly to take it a bit easier and also to be nearer to his grandchildren, he moved back to Omaha and practiced in Benson until 1972 when he retired due to illness. Even after retirement and when he himself was ill, he had a few patients that came to see him in his home or he made house calls on some who couldn't get out, as he had always done.

Dr. Antony is a member of the Kansas, Nebraska and Douglas County Medical Societies and the A.M.A. He is a 4th degree Knight of Columbus.

NOTE: The aforementioned was submitted by his family because of Dr. Antony's illness, and at his request and with his knowledge.

The Specialist

THE PSYCHIATRIST

If people live in dream houses, this doctor collects the rent. His patients never get better or worse, and they don't die. His jargon is nothing like ours, and once he had a thing called dementia praecox, which he also said was the insanity of the young, only then he decided it wasn't dementia and it wasn't praecox, either, so now we have to say and spell schizophrenia, which has got to be the worst word ever made up by an otherwise sane doctor.

Penumonia, broken bones, x-rays, hemorrhage, and cancer do not concern him. His field is just what goes on inside your head, and then only if it is what is laughingly called functional. His patients stare at inkblots, and now they've changed the answers to the questions, and they lie on couches. I think Freud started the couch business, and he did it so the patients couldn't see him make faces as he listened to the silly things they said.

His field has been broken through several times, by shock therapy, by lobotomy, and by the tranquilizers; at one time, more people were tranquil than anyone realized. Of course, people have been tranquil for years, but head shrinkers use chemicals with long names instead of goodnatured alcohol.

He has succeeded in confusing many of us; just when you learn what a neurosis is, and a psychosis, he talks of a psychoneurosis. And if you think a person with a psychosis is psychotic, whatever that means, he comes up with people with schizophrenia who seem to be all right. He goes glibly from personality disorder to conversion to psychosomatics, and from paranoia to paranoid, and buries you in a multitude of names, until you don't know if the patient is sane or not, and if anybody knows.

We are fond of saying that we inhabit a tense world, but I don't know if it is tenser than it was.

I wonder whatever happened to analysis, and to the alienist.

F.C.

Down Memory Lane

1. Up to 1914 the treatment of diabetes was notoriously unscientific. In December of that year Allen published his work on total dietary restriction in the treatment of the diabetic.

2. When one considers the great number of pneumonias developing from the 1918-1919 pandemic of influenza, the evident virulency of the offending organisms, the usual widespread and massive involvement of the lungs, all resulting in rapid depletion, toxicity, and complications, it is surprising to find that out of 2,577 cases of pneumonia at Camp Travis base hospital, there developed only nineteen cases of empyema, and fourteen cases which might be considered as effusions or abortive empyemas.

3. Results after periarterial sympathectomy are not constant.

4. In England and Wales the death rate of appendicitis is not decreasing, being about 2500 deaths a year. It is not decreasing in our country. There is still, too often, delay in operating, and there are too many illy-trained, injudicious operators.

5. A study of roentgenograms taken of constipated children nearly always shows a looped, twisted, redundant dilated and hypertrophied sigmoid which makes it impossible

to say just what degree of distention constitutes a mild case of megacolon.

6. Insulin has long since passed the experimental stage and the indications for its use are definitely marked out.

7. It is extremely difficult for members of the medical profession to understand the attitude of the lay mind in relation to the art and science with which we are most concerned.

8. What little prevention and constructive health work we are able to do, we must force on the public with a club; and vast possibilities in the way of preventing suffering and of building up stronger, healthier men and women, are simply untouched by medical men, and undreamed of by the laity.

Nebraska State Medical Journal
March, 1924

Between Cases

On Otitis (1).

Dictated: "Does well here."
Typed: "Does hear well."

The Consultation (a).

"Can anything be more doleful than a procession of four or five doctors into the sick man's room?"

Osler

Advice From An Older Surgeon.

Never thread a needle; the nurses just stand there and laugh at you.

On Politics.

Garfield was our only left-handed President.

The Impression.

"Impression was scoliosis of the left leg."

Words We Can Do Without (1).

Juncture, junket, deboarding, multimedia, crunch.

Which Came First?

A chicken is just an egg's way of making another egg.

On Otitis (2).

"Arthritis media, left, chronic."

Cole's Chill Index.

If you can see your breath when you go out, don't go out.

Send me the royalties.

On Consent.

"Many patients can face danger with less fear if they are spared the exact specifications of risk."

Anon.

The Consultation (b).

"Ligamentous instability is quite good."

Riddle Department.

Q: What is white and goes quack quack?
A: A disillusioned nurse.

This Month's Psychology Lesson.

Women hang up phones backward.

What We Are Doing About The Gasoline Situation.

Most of the doctors driving down Lincoln streets are staying under 55 MPH; I think Omaha doctors are doing the same on 16th, and maybe on Dodge, and I have an abiding confidence in all other Nebraska physicians.

I haven't been on the interstate recently, so my survey is confined to city streets, but I can assure you that we are cooperating.

This Month's Note To The Specialists.

(a) What is the difference between a neurosis and a psychosis?

(b) What is the difference between a sprain and a strain?

I Agree With Socrates.

"To use words wrongly is not only a fault in itself, it also corrupts the soul."

The Consultation (c).

"X-ray examination of the tibia on the left reveals normal abnormality in the bony structures of the left lower leg."

Department Of Euphemisms.

"The blood pressure could not be restored."

Words We Can Do Without (II).

Bemused, shortfall, catchment, remiss, albeit, the name of the game.

Murphy's Law.

If something bad can happen, it will.

The Physical.

"Examination of the ankles—because this joint has limited movement the ankle motion appears to be normal in all directions."

Chief Complaint.

"Loss of impotency."

On Statistical Analysis (Part One).

"Some people never read certain digits."

Cyril Maxwell.

On Statistical Analysis (Part Two).

Student's "t" test was invented by Fisher. He signed his article, "Student."

You Could Look It Up.

On page 1465 of the American Heritage Dictionary, there is a picture of wild ginger, which looks more like a picture of two kidneys and ureters to me, but then I'm a doctor.

On Time.

"Ah! the clock is always slow;
It is later than you think."

R. W. Service

F.C.

Our Medical Schools

The University of Nebraska Medical Center will offer several postgraduate courses in April.

1. There will be a course, on April 4 and 5, on infectious disease and clinical medicine.

Guest faculty includes Dr. John G. Bartlett, staff physician at the Sepulveda Veterans Administration Hospital, Sepulveda, California, and assistant professor of medicine, University of California at Los Angeles School of Medicine; and Dr. Leighton E. Cluff, professor and chairman, department of internal medicine, University of Florida School of Medicine.

Course coordinator is Dr. Richard B. Davis, professor of internal medicine at Nebraska.

The course is acceptable for 15 prescribed hours by the American Academy of Family Practice. The fee of $50 includes lunches.

2. Urinary tract problems will be the subject of a course to be offered April 10 in Harlan, Iowa; April 11 in McCook; and April 12 in Chadron.

Dr. Francis Bartone, chairman of the department of urology at Nebraska, is course coordinator. Dr. Sushil S. Lacy, assistant professor of urology at Nebraska, is also on the faculty.

The course in Harlan will be hosted by Dr. Joseph Spearing. The McCook session will be in the Elks Club, hosted by the Southwest Nebraska Medical Society. Chadron State College will be the site of the April 12 course, hosted by the Northwest Nebraska County Medical Society.

Registration fee of $25 for physicians and $15 for nurses includes dinner. The course is acceptable for four prescribed hours by the American Academy of Family Practice

and for .4 Continuing Education Units for nurses.

3. The Medical Center faculty will conduct four off-campus courses focusing on perinatal subjects. The conferences will be held April 17 at the Tall Corn Motel in Shenandoah, Iowa; April 24 at the Holiday Inn in Norfolk; May 1 at the Ramada Inn in Scottsbluff; and May 2 at the Elks Club in McCook.

Dr. Yoshio Miyazaki, associate professor of pediatrics, is coordinator of the conferences.

The conferences are acceptable for 5 prescribed hours by the AAFP and .5 C.E.U.S.

The registration fee of $25 for physicians and $15 for nurses includes dinner.

4. Home health care will be the subject of a course April 23 and 24 at the Ramada Inn in Kearney. This course is designed for nurses, hospital and nursing home administrators, physicians, social workers and others interested in home health care.

Guest faculty includes Burney Bouslough, project coordinator for the Nebraska Hospital Association; Vivian Cresswell, director of social services, Immanuel Medical Center, Omaha; Dr. Donald Gentry, chairman, Home health medical advisory committee, Scottsbluff; Shirley Harms, director, Home Health Care Agency, Mary Lanning Hospital, Hastings; Dr. Kenneth Kimball, Kearney physician; Martha Maseman, president, Nebraska Home Health Care Association; Mary Munter, State Department of Health; Hulda Osborne, State Department of Health; Eva Phelps, Omaha Visiting Nurses Association; Greg Pilotte, health care planner, Grand Island; DeLanne Simmons, director, Visiting Nurses Association, Omaha; Dr. Henry Smith, director, State Department of Health; and Mary Lee Whyte, Visiting Nurses Association, Omaha.

Special guest faculty includes Marcella Haugh, nurse consultant for Region VII, Department of Health, Education and Welfare, Kansas City, Missouri; Senator Thomas C. Kennedy, Newman Grove, Nebraska; Dr. Hugh Rohrer, president, National Association of Home Health Administrators; and Dr. Claire Ryder, Home Health Branch, Division of Human Resources, Department of Health, Education and Welfare, Rockville, Maryland.

Course coordinators are Martha Maseman and Lorraine Hedman, director of continuing education for nurses at the University of Nebraska Medical Center.

The tuition fee of $30 includes two luncheons.

The course would qualify for 1 C.E.U. hour.

5. A nursing leadership course concentrating on self concept, leadership styles and decision making will be conducted at the Medical Center April 18 and 19.

Guest faculty includes Beatrice Chase, consultant to the Memorial Sloan-Kettering Cancer Center, New York City; Darlene Cording, executive director of the Nebraska Nurses Association; Dr. Pat Forni, project director, Midwest Continuing Professional Education for Nurses, St. Louis, Missouri; Marlene Kramer, professor of nursing, University of California School of Nursing, San Francisco; and Ruth Murray, associate professor of nursing, St. Louis University.

The registration fee of $30 includes lunches.

The course will qualify for 1 hour of C.E.U.

Lorraine Hedman is program coordinator.

Welcome New Members

R. A. Blatny, M.D.
Fairbury, Nebraska 68352

W. Benton Copple, M.D.
Immanuel Hospital
Omaha, Nebraska 68111

Allen D. Dvorak, M.D.
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Omaha, Nebraska 68108

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Gering Nebraska 69341

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Lincoln, Nebraska 68502

George J. Wolcott, M.D.
600 North Cotner
Lincoln, Nebraska 68505

In Memoriam

By medicine life may be prolong'd
yet death
Will seize the doctor too.

—Shakespeare

DR. EUGENE G. EWING

Doctor Eugene G. Ewing died on January 2, 1974 at the age of 63. Doctor Ewing was born in Creston, Nebraska on December 8, 1910.

He graduated from the University of Nebraska College of Medicine in 1935, following which he practiced in Laramie, Wyoming, and served in the Army Medical Corps.

Doctor Ewing began his practice in Madison, Nebraska in 1958, where he stayed until retiring in 1970.

He is survived by a son, Joe Ewing of California; a daughter, Ann of Denver, Colorado; two sisters, Mrs. Helen Kiesseback and Mrs. Monte Hansen, both of California; and two grandchildren.

DR. WARREN D. HANSEN

Doctor Warren D. Hansen died on January 1, 1974 at the age of 64. Doctor Hansen was born in West Point, Nebraska on September 28, 1909.

He was graduated from the University of Nebraska College of Medicine in 1936.

Doctor Hansen started his medical practice at Winside and later moved to Wisner where he practiced for 26 years. He then spent nine years as a general practitioner at the Norfolk Regional Center prior to returning to practice in Wisner in April, 1973.

Survivors include his widow, May; a son, Brian of Littleton, Colorado; one grandson; and two sisters, Mrs. Bayard (Evelyn) Davis of North Highlands, California; and Mrs. Gerald (Viola) Gray of Jefferson City, Missouri.

DR. CARL H. L. STEHL

Doctor Carl H. L. Stehl was born in Gosper County, Nebraska, on October 16, 1908. He died on January 12, 1974 at the age of sixty-five.

He was graduated from the University of Nebraska College of Medicine in 1934.

Doctor Stehl practiced at Scribner from 1936 until 1963, following which he practiced at the Norfolk Regional Center until 1970 as a staff physician. He served as a staff physician at the Lincoln Regional Center in 1970 and 1971.

Survivors include his wife, Anna; one son and four daughters, Rudolph of Midland, Michigan; Mrs. Sidney (Susan) Stoh of Lincoln; Mrs. Vernon (Becky) Souders of Scottsbluff; Mrs. Gerald (Martha) Rus of Cleveland, Ohio; and Mrs. Frieda Kahre of Seward; and seven grandchildren.

WashingtoNotes

Medicare & Medicaid

The AMA has branded as "wrong medically, wrong morally, and wrong legally" the Health, Education, and Welfare Department's proposed regulation requiring prehospital-admission certification for Medicare and Medicaid patients.

AMA President Russell B. Roth, M.D., and Board Chairman James H. Sammons, M.D., at a press conference in Chicago made the following statement:

"We are here today to serve notice on Secretary Weinberger that if he proceeds with two proposed actions, we are going to take him to court.

"Earlier this month, the Secretary of the Department of Health, Education, and Welfare issued a set of proposed regulations that would require preadmission certification for Medicare and Medicaid. If adopted as proposed, they would require that every Medicare and Medicaid patient be cleared by a Utilization Review Committee before admission to a hospital. The only exception would be emergency cases.

"These regulations are a direct threat to the medical care of the 35 million or so patients who are served by Medicare and Medicaid. For most of them, the withholding of Medicare or Medicaid hospital benefits will mean they will be denied hospitalization because they have no other means to pay for their care.

"Any such denial of medical care represents a clear violation of both the spirit and the letter of the Medicare-Medicaid law. Congress clearly established the programs to provide medical care for the elderly and the poor. What the Congress has given, the Secretary now seeks to take away. The Secretary has no authority under the guise of regulations to amend the law and reduce benefits. He has no moral or legal right or authority to do so. Indeed, his action is as illegal as it is reprehensible. The Medicare-Medicaid law provides for preadmission certification by the patient's physician and for postadmission review by hospital utilization review committees. The Congress did not intend that a committee substitute a paper decision for the judgment of a patient's physician. The Secretary's proposal is a direct and clear violation of Section 1801 of the Medicare-Medicaid law.

"We would welcome support from all interested parties, such as senior citizens organizations and consumer groups. We would hope they would join in our action. But with them or without them, we will be in court on the day those regulations are promulgated."

Fees and charges

Physician fees in 1974 have been ordered held to a four percent increase by the Cost of Living Council.

As in November regulations, physicians under Phase IV will be permitted an annual aggregate fee increase of four percent. A ten percent maximum fee increase is allowed for specific charge items; fees under $10 can be raised by $1.

The limits are effective as of the first of this year. They remain legally in effect until April 30, by which time Congress must authorize an extension of the President's powers to impose wage-price controls, or they will expire. There is growing sentiment in the Senate and the House to terminate the program.

The regulations in the health field have been under court attack. Nursing homes have won a preliminary legal battle in their suit against the Phase III controls. The American Hospital Association has threatened to challenge the controls in court.

Hospitals were restricted to a 7.5 percent increase per in-patient stay, with adjustments for volume changes.

Under the final regulations, all physicians must maintain a schedule showing

Sign of a cold* sufferer

Time for Ornade®

Each Spansule® capsule contains 8 mg. Teldrin® (brand of chlorpheniramine maleate); 50 mg. phenylpropanolamine hydrochloride; 2.5 mg. isopropamide, as the iodide.

Fast relief of nasal congestion and hypersecretion* with convenient b.i.d. dosage.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Possibly effective: For relief of upper respiratory tract congestion and hypersecretion associated with vasomotor rhinitis and allergic rhinitis, and for prolonged relief.

Lacking in substantial evidence of effectiveness: For relief of nasal congestion and hypersecretion associated with the common cold and sinusitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Warn patients of possible additive effects with alcohol and other CNS depressants.

Usage in Pregnancy: In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

Effect on PBI Determination and I^{131} Uptake: Isopropamide iodide may alter PBI test results and will suppress I^{131} uptake. Substitute thyroid tests unaffected by exogenous iodides.

Precautions: Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.

Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

Supplied: Bottles of 50 capsules.

SK&F Smith Kline & French Laboratories
Division of SmithKline Corporation, Philadelphia, Pa. 19101

The irritations of man's day are often reflected in his gut.
The causes of irritable colon and the diarrheal symptoms that often accompany it can be as diverse as the systemic and emotional irritations man is faced with daily.
Although the mucoid nature of stools and the occurrence of diarrheal episodes coincident with times of emotional stress may be valuable clues to the functional nature of the disorder, irritable colon must often be diagnosed by exclusion. Such diagnostic exploration takes time. Discovery of the nature of any emotional problems may take more. During that time, Lomotil® is an ideal agent for controlling diarrheal symptoms.
Lomotil tablets are small, easy to carry and easy to take. They act promptly and effectively. Secondary effects are relatively infrequent and, once the first force of the diarrhea is controlled, maintenance is frequently effective on as little as one fourth of the initial dosage.
These same characteristics make Lomotil useful in controlling the diarrhea associated with gastroenteritis, antibiotic therapy and acute infections.

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

Lomotil®

TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
diphenoxylate hydrochloride . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.

takes care of the gut issue in irritable colon

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Integument!

Our skin—the human integument—covers us, defines us, protects us. But skin is subject to cuts, burns, abrasions. And infections. Neosporin Ointment fights infection by providing broad antibacterial action against susceptible skin invaders. It contains antibiotics that are rarely used systemically, reducing the risk of sensitization.

INDICATIONS: *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

NEOSPORIN® Ointment

(POLYMYXIN B-BACITRACIN-NEOMYCIN)

Each gram contains: Aerosporin® brand Polymyxin B Sulfat 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg. neomycin base); special white petrolatum q.s. In tubes of 1 oz. and ½ oz. and 1/32 oz. (approx.) foil packets

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

prices in effect on December 28, 1973, which comprises 90 percent of their revenues, and the subsequent changes and dates. "A conspicuous and easily readable sign" must be posted stating the availability and location of the price schedule. The requirement applies whether or not fees have been increased.

HMO

President Nixon is enthusiastically endorsing the Health Maintenance Organizations program effort getting underway at the HEW Department, according to federal health officials.

Proposed regulations to carry out the HMO program will be issued by the end of March.

Health spending

Health outlays last fiscal year for the nation reached $94.1 billion, an 11 percent increase, the lowest rate in several years. The proportion of total health spending to the Gross National Product remained at the 1972 level — 7.7 percent. Per capita expenditures rose $41 to $441, including private and government spending.

The Social Security Administration's preliminary figures for the fiscal year that ended last July showed per capita private spending on health of $265 and government spending of $176 per person for the year.

The ratio of public versus private health spending continued the trend of two decades toward more government spending. The ratio for fiscal 1973 was 60.1 percent private and 39.9 percent public. In 1928, the corresponding ratio was 86.7 percent and 13.3 percent.

Of the $94 billion total, $36 billion went for hospital care, $18 billion for physicians' services, compared with $32.6 billion and $16.6 billion the previous year.

Federal spending was estimated at $24.6 billion, up almost $2 billion; state and local, $12.9 billion, up more than $1.5 billion.

Expenses for prepayment and administration, largely private health insurance expenses, rose from $2.4 billion in fiscal 1972 to $3.3 billion in fiscal 1973.

Additional information?

The AMA recognizes that supplemental printed information given to the patient by the pharmacist at the physician's discretion would be valuable for certain classes of drugs.

However, the AMA stated at a Washington, D.C., conference on patient drug information that the preparation and distribution of such informational material pose a number of problems.

"Patients differ in their drug requirements with respect to dose, duration of therapy and adjunct medication. They also differ in therapeutic response, adverse side effects and toxic reactions. The information in a 'patient package insert' might be helpful to some patients but might confuse, frighten or even harm other patients."

SCHEDULE OF UPCOMING NCME PROGRAMS

February 25 - March 10

GLAUCOMA DETECTION IN THE NON - OPHTHALMOLOGIST'S OFFICE.

THE FIVE-MINUTE JOINT EXAM.

PULMONARY EMBOLISM: A RATIONAL APPROACH TO MANAGEMENT.

March 11 - March 24

DIAGNOSIS OF SINUSITIS.

THE BREAST EXAMINATION.

AN EFFECTIVE WAY TO CONTROL PSORIASIS.

March 25 - April 7

ALOPECIA IN DIAGNOSIS.

THE MEDICAL MANAGEMENT OF METASTATIC BREAST CANCER.

THE DIFFERENTIAL DIAGNOSIS OF SYSTEMIC LUPUS ERYTHEMATOSUS.

Coming Meetings

CRIPPLED CHILDREN'S CLINICS —
March 2 — Kearney, Elks Lodge
March 23 — Sidney, Elks Lodge
April 6 — Broken Bow, Elks Lodge
April 27 — Norfolk, Elks Lodge

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS — Symposium and Winter Workshop; New Orleans, March 19-22, 1974. Write to: The American College of Emergency Physicians, 241 E. Saginaw, East Lansing, Michigan 48823.

"LIFE-SAVING MEASURES FOR THE CRITICALLY INJURED" — Sponsored by the American College of Surgeons Committee on Trauma and the department of surgery, University of South Florida, Tampa, March 27-30, 1974. The seminar is designed particularly for rural and general practitioners, physicians called upon most frequently to render primary medical care to the injured. Though aimed at the nonspecialist and emergency department physician, the broad curriculum is also useful to surgical specialists and internists. This three-day course at the Holiday Inn Downtown, is one of 16 being held throughout the U.S. during 1973-74, by the Trauma Committee in cooperation with departments of surgery. A faculty of 17 experts in the field of trauma, will report on the latest in care of the injured. The Seminar is approved by the AMA for credit toward Physician's Recognition Award, by the American College of Emergency Physicians for continuing education credit for members, and by the American Academy of Family Physicians for 21 credit hours. Sites for the remaining 1974 courses include: Washington, D.C. (April 16-19); Cincinnati (May 22-25); New Haven, Conn. (June 17-21); Los Angeles (Sept. 11-14), and Chicago (Sept. 18-21).

RURAL MEDICAL DAY — April 17, 1974, University of Nebraska College of Medicine, Omaha and Creighton University School of Medicine, Omaha.

M-I-N-K — The Tri-annual joint meeting of the Missouri, Iowa, Nebraska and Kansas Dietetic Associations will be held in Omaha, Nebraska at the Holiday Inn, 72nd and Grover Streets (I-80 and 72nd Streets); April 18th and 19th, 1974; write to: Department of Continuing Education, University of Nebraska Medical Center, 42nd and Dewey Streets, Omaha, Nebraska 68105. Together We Step Into Tomorrow.

NEBRASKA MEDICAL ASSOCIATION — Annual Session, April 28 - May 1, 1974, Hilton Hotel, Omaha, Nebraska.

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS — 22nd Annual Clinical Meeting, April 29 through May 2, 1974, Las Vegas, Nevada. Registration fee for non-members: $125.00. Contact: Mr. Donald F. Richardson, Associate Director, The American College of Obstetricians and Gynecologists, One East Wacker Drive, Chicago, Illinois 60601.

SEMINAR ON ADVANCES IN PEDIATRICS — 14th Annual, at Childrens Memorial Hospital, Omaha, June 6, 7, and 8, 1974. The Seminar is jointly sponsored by the Hospital, Creighton University School of Medicine, and the University of Nebraska School of Medicine. Speakers will include: Dr. H. William Clatworthy, Ohio State University, Pediatric Surgery; Dr. George H. McCracken, Jr., University of Texas, Infectious Disease; Dr. Omar Burgert, Mayo Medical School, Hematology - Oncology; Dr. Joseph E. Ghory, Convalescent Childrens Hospital, Cincinnati, Ohio, Allergy; and faculty members of both local Medical Schools. The registration fee is $50 and includes continental breakfast and lunch. Write: Seminar Committee, Childrens Memorial

Hospital, 44th and Dewey, Omaha, Nebraska 68105 for further information.

AMERICAN MEDICAL ASSOCIATION — Annual Session, June 22-27, 1974, Chicago, Illinois.

NEBRASKA MEDICAL ASSOCIATION — Fall Session, October 3-5, 1974.

AMERICAN ASSOCIATION FOR CLINICAL IMMUNOLOGY AND ALLERGY — Annual Meeting; Pier 66, Ft. Lauderdale, Florida, November 21-24, 1974. Write to: John L. Dewey, M.D., P. O. Box 912, DTS, Omaha, Nebraska 68101.

AMERICAN MEDICAL ASSOCIATION — 28th Clinical Convention, December 1-4, 1974, Portland, Oregon.

Medicinews

President on health

In his State of the Union Message, President Nixon commented ". . . the time is at hand this year to bring comprehensive high quality health care within the reach of every American. I shall propose a sweeping new program that will assure comprehensive health insurance protection to millions of Americans who cannot now obtain it or afford it, with vastly improved protection against catastrophic illness." Ater outlining the philosophies of his approach, Mr. Nixon concluded the health portion of his message, stating, "The right way is one that builds on the strength of the present system and one that does not destroy those strengths . . . Government has a great role to play, but we must always make sure that our doctors will be working for their patients and not for the federal government." A general outline of the Administration's proposal was reported recently in the Roundup. Soon the President is expected to present his Health Message to the Congress at which time the details of the Administration's national health program, and other health programs will be made known.

AMA responds to Washington

Preadmission Approval . . . AMA President Russell B. Roth, M.D., and Board of Trustees Chairman, James H. Sammons, M.D., held a press conference to announce two actions which had just been taken by the Board of Trustees. Doctor Roth announced that the AMA would file suit against the Secretary of HEW if the Secretary promulgated final regulations which would require pre-admission approval for non-emergency hospital admission under Medicare and Medicaid, on the basis that it represents ". . . a clear violation of both the spirit and the letter of the Medicare-Medicaid law." Doctor Roth also announced that AMA will join any suit filed by a state medical society which seeks to upset the Secretary's PSRO area designations within that state. In addition, recently, the AMA sent telegrams to HEW and the Social Security Administration urging an additional 30 days be given for comment on proposed regulations revising existing utilization review procedures under Medicare and Medicaid, and instituting pre-admission approval requirements for elective admission to hospitals and other health facilities under these programs. The proposed regulations were published in the Federal Register on January 9, 1974 . . . *Communications for Emergency Medical Services.* The AMA also sent a letter to the Federal Communications Commission urging them to take action implementing the recommendations contained in the Advance Technology System Report and the Report of the Interagency Radio Advisory Committee as they relate to the establishment of radio communication networks within community emergency medical services systems so as to allow communications between the various specialized EMS personnel . . . *Gasoline Rationing.* The AMA

also filed comments recently on the proposed Gasoline Rationing Contingency Plan, urging that specific provision be made for physicians, and other health care personnel, so as to assure that they will have sufficient gasoline to carry on the care of patients. In addition, the Association asked that delivery sources of gasoline be developed so that physicians may have access to gasoline during reasonable hours, as well as alternative sources for their emergency needs at all hours. A similar plea was made for an adequate gasoline allocation for emergency medical vehicles. The Federal Energy Office was apprised by the AMA of the deleterious effects on the availability of health care which are likely to occur unless such specific provisions were included in any gasoline rationing program.

Family practice

The American Board of Family Practice announces that it will give its next two-day written certification examination on October 19-20, 1974. It will be held in five centers distributed throughout the United States. Information regarding the examination may be obtained by writing: Nicholas J. Pisacano, M.D., Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Kentucky 40506.

Please Note: It is necessary for each physician desiring to take the examination to file a completed application with the Board office. Deadline for receipt of applications in this office is *June 15, 1974.*

Books

Books reviewed

Current Medical Diagnosis and Treatment, by Marcus A. Krupp, M.D., Milton J. Chatton, M.D., and associated authors; 18 by 26 cm (7 by 10¼ in.); 1018 pages; limp cover $12.00; published 1974 by Lange Medical Publications, Los Altos, California.

This book has appeared in a new edition every year since 1962; this version has 22 more pages than last year's and costs the same. There are 31 chapters, an appendix, and a good index; the whole thing was put together by 33 authors.

It is a good book; it has been translated into Spanish, Italian, Romanian, Serbo-Croatian, German and Portuguese. I have reviewed it before, in several editions, and always favorably.

It is up to date and thorough; there are many references; it is well written. The printing is good; and the index is excellent. I recommend it.

F.C.

Books received

Paroled But Not Free, by Rosemary J. Erickson, Wayman J. Crow, Louis A. Zurcher, Jr., and Archie V. Connett; 129 pages, $4.95 softbound; published 1973 by Behavioral Publications, New York.

The Prevention of Crime, by Stuart Palmer; 277 pages, $9.95 hardbound; published 1973 by Behavioral Publications, New York.

The Letter Box

To the Editor:

I would like to respond to the article by J. Whitney Kelley, M.D., in the January issue of Nebraska Medical Journal on "Medical Students and Future Membership in Organized Medicine." As a medical student who has heavily involved himself in organized medicine, serving as a national officer in the Student American Medical Association (SAMA), a voting member of the Council on Health Manpower of the AMA, and one of the founding officers of the AMA's Medical Student Business Session, I believe Dr. Kelley has identified a true problem; however, his excellent suggestions must only be a beginning to a more complete involvement of students in the Nebraska Medical Association (NMA).

One of the largest factors recently causing medical students to question the validity of organized medicine was the AMA's well publicized opposition to Medicare. I fear the opposition and reluctance on the part of organized medicine to work with PSRO for proper implementation will sound the death knell for the future effectiveness of organized medicine to represent the profession. Students are thoroughly disgusted by the fact that many cruicial decisions which affect their future are being made by near retirement physicians without medical student input.

The NMA is not found to be without fault in its involvement of students in decision making. Even the implementation of student membership into the NMA was done without asking the students how it should be done. The NMA created new student organizations at Nebraska and Creighton when there were already active, functioning student organizations in the form of SAMA chapters.

The Creighton Student Council which doubles as a SAMA chapter, and the Nebraska SAMA Chapter have a fine record of project activities, including the MECO Project. The University of Nebraska chapter has a membership of 340 which makes it the eighth largest SAMA Chapter in the nation.

SAMA is totally *independent* of the AMA, yet at SAMA's insistance a student Business Session of the AMA was created with three of the five officers being appointed by SAMA. In addition, SAMA appoints student members to the councils and committees of the AMA and also to the commissions of the American Academy of Family Physicians. The AMA, to their credit, as well as a number of state societies have made a hearty attempt to involve medical students in organized medicine.

There is much to be done to encourage students involvement in organized medicine in Nebraska, and it is up to those of us who see its value to bring it about.

Sincerely,

Steven Plettner, M.D.
National Vice President
Student American Medical Assn.

cc: Dr. Coe, President NMA
Dr. Land
Tim Chapple, SAMA President, Nebraska
Andy Klonecke, SAMA President, Creighton

Dr. Kelley replies:

Dear Dr. Plettner:

I am very pleased that you chose to answer my note about the article which I wrote in January to further encourage involvement of medical studentse in the Nebraska Medical Association. I have been a hearty advocate of a more close relationship between the doctors and the future physicians and at least have been an ingredient to the development of a more close relationship than has been existent in the past. I am pleased that you feel that I have identified the true problem but I am not completely sure that your criticism of the mechanism that we used is valid.

I believe that a considerable input from the medical students and the house officers is a very necessary ingredient in the development of a fully rounded program in so far as organized medicine is concerned. I believe that by only such an association could the physicians, who are near retirement, explain their positions on PSRO and medicare which you seem to find unpalatable. I would be willing to accept and I know the members of the Nebraska Medical Association would not only be willing to accept but to listen to any advice and ideas that might come from the students concerning their feelings about both PSRO and medicare. I am quite sure that your statement that students are thoroughly disgusted by our attitudes toward this particular subject is a representation of your own feelings more than that of the cross-section of the SAMA, though I could be wrong. I have had quite a close association with medical students in my medical school because I happen to be a professor in the medical school and have talked with the students quite frequently.

The Nebraska Medical Association is not a great deal different than any other medical association. It is primarily conservative in that it resists too rapid change and to have the basic format of how organized problems in organized medicine should be accomplished would seem to me that the mechanics would be better handled by persons who are experienced in the field rather than someone who is just embarking on the course of being involved in organized procedures. Your description of the power of SAMA both at Nebraska and Creighton does not completely fit my understanding of the relationship, though I am quite aware of the existence of both chapters at SAMA. However, we at the Nebraska Medical Association have felt that while SAMA might represent a fair percentage of the medical students in each of the two medical schools, we felt that the involvement of students should be 100% rather than just partial. And for that reason we accepted our delegation to the state convention from the whole student body rather than those individuals who chose to join your organization.

As you probably know, there are two medical associations in the United States which are quite powerful, ours being the larger because it is the older. Nevertheless, we do not believe that the opinions of our medical brothers in the National Medical Association should have their feelings and ideas ignored and we also believe that if Congress were to consult one organization without the other it would constitute class discrimination.

We at the Nebraska Medical Association and indeed in our local county societies have already implemented a number of the ideas which were suggested in that article and intend to continue and develop them further. We shall also continue to involve members of the SAMA and other student members of medical association because they too will become physicians.

Thanks very much for your courtesy in answering this note and for the thoughts involved. Rest assured that I will do everything that I possibly can to incorporate the ideas which you have suggested in order to make our plan a more perfect one, I am

Yours fraternally,

J. Whitney Kelley, M.D.
Clinical Professor of
Neuropsychiatry,
Creighton University

Dear Frank:

I was hoping to talk to you personally about your generous and glowing eulogy of the neurosurgeon as it appears in the state medical journal. I have never seen anything so flattering in my life.

Rest assured, you are my friend for ever.

Very sincerely yours,

Louis J. Gogela, M.D.

To the Editor:

Forty-two patients, ages ranging from 7 to 61, were started on daily inhalation use of cromolyn sodium. Their average age was 31.

Thirty of these patients had been receiving steroid therapy in addition to the usual bronchodilators. Of this group of 42 patients, 18 experienced rather dramatic remissions of their bronchial asthma. Of the remaining 24, 10 of them received rather marked improvement.

One patient had what appeared to be an anaphylactoid reaction to the inhalation of cromolyn, as experienced by severe bronchospasm, periorbital edema, and generalized urticaria.

In the remaining patients, no beneficial benefit was noted. In the patients receiving rather dramatic and those moderate reduction in symptomatology, a marked reduction in the amount of steroid maintenance therapy was noted. Ten patients at this time are receiving no steroid treatment, and with the inhalation of cromolyn are asymptomatic. In the remaining percentage of those receiving relief, the amount of steroid has been reduced by approximately 50 percent.

In conclusion, I believe that cromolyn is a very useful adjunct to the treatment of acute bronchial asthma, and may be especially useful in the patient with peptic ulcer, diabetes, and other conditions in which steroid therapy is contraindicated.

Respectfully,

Ben R. Meckel, M.D.

Subacute Sclerosing Panencephalitis and Salk Vaccine — D. M. Baguley (School of Medicine, Univ of Auckland, Auckland, New Zealand) and G. L. Glasgow. Lancet 2: 763-765 (Oct 6) 1973.

From 1956 to 1966 the incidence of subacute sclerosing panencephalitis (SSPE) in the northern half of the North Island of New Zealand was approximately 100 times greater than might be expected. The incidence of the disease was greatest in the late 1950s, then it waned and was associated with an increasing age at onset of symptoms. Mass vaccination of primary school children with Salk vaccine was begun in 1956. The vaccine used is likely to have contained live SV40 virus and thus to have caused the appearance of SSPE. The idea that an unusual reaction to measles infection is the sole cause of SSPE is not consistent with the observations in New Zealand.

Cardiac Arrest Due to Hyperkalemia Following Intravenous Penicillin Administration —C. W. Mercer and J. R. Logic (951 Court Ave, Memphis 38103). Chest 64:358-359 (Sept) 1973.

Two episodes of cardiopulmonary arrest occurred after the rapid intravenous administration of potassium penicillin G in a 60-year-old black woman with streptococcal endocarditis and sepsis. Asystole, ventricular fibrillation, and atrioventricular block suggested a positive relationship of these abnormalities to the rapid change in concentration of serum potassium produced by the injections. The fact that 1×10^6 units of potassium penicillin G contain 1.7 mEq K+ suggests that caution should be employed in the rapid intravenous administration of this antibiotic even in patients with normal serum electrolyte levels and a normal electrocardiogram.

Value of Follow-up After Treatment of Basal Cell Carcinoma — E. Epstein (36 S El Camino Real, San Mateo, CA 94401). Arch Dermatol 108:798-800 (Dec) 1973.

In a prospective study of the value of long-term follow-up after treatment of basal cell carcinoma, new skin cancers were found in 20% of the patients examined during a one-year study period. The majority of these new skin cancers were unsuspected by the patient. The risk of new skin cancer was directly related to the number of previous basal cell carcinomas. Long-term follow-up for patients with skin cancer is indicated to detect new tumors. All patients having had two or more previous basal cell carcinomas should be followed indefinitely.

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Advertisements in this column are at a rate of ten cents per word with a minimum of $4.00 per insertion. Copy must be received by the fifth of the month preceding date of publication and should not exceed 50 words. Advertisements from members of the Nebraska Medical Association will be accepted without charge for one issue. Each advertisement will be taken out following its first appearance unless otherwise instructed. Where numbers follow advertisements, replies should be addressed in care of The Nebraska Medical Journal. 1902 First National Bank Building, Lincoln, Nebraska 68508.

CLINIC AVAILABLE — General practice in furnished clinic. County seat town, SW Nebraska. Three nursing homes in town, good territory. Equipped office available for dentist. Write Box 8, Beaver City, Nebraska 68926.

GENERAL PRACTITIONERS NEEDED — County seat town, North-Central Nebraska. Clinic available across street from modern 34-bed hospital. Three nursing homes nearby, large trade area. Affiliation possible if desired. If interested, call or write Charles Sweet, M.D., 140 South 4th; Roy J. Smith, M.D., 732 West Fairview; or Administrator, Boone County Community Hospital, Albion, Nebraska 68620.

IMMEDIATE OPENING — For Ob-Gyn., Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

LOCUM TENENS WANTED — Available for 1-2 week periods from April to September. Experienced in general medicine and general surgery. Total of four weeks to schedule. Contact: Robert H. Westfall, M.D., 201 Ridge Street, Council Bluffs, Iowa 51501.

MEDICAL OFFICE FOR RENT OR LEASE — Cot-Nor Incorporated Suite 500 with 1,015 sq. feet located at 5440 South Street, Lincoln, Nebraska. Abundant parking available. If interested, contact Mr. Dick Gaughan, Manager of Cot-Nor Incorporated, Suite 1600, 5440 South Street, Lincoln, Nebraska 68506. Phone: (402) 489-2718.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg —bottles of 100 and 500; Tel-E-Dose® packages of 1000. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg —bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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to help reduce clinically significant anxiety and thereby help improve patient receptivity

Librium® (chlordiazepoxide HCl)

up to 100 mg daily in severe anxiety

Please see following page.

Symptom of excessive anxiety:

The patient may have difficulty in accepting medical counsel.

Clinical experience has shown that some unduly anxious patients may tend to deny or minimize their illness and therefore resist seeking or following medical advice. Through its antianxiety action, adjunctive Librium (chlordiazepoxide HCl) can often calm the emotionally tense patient, thereby encouraging physician-patient rapport and, on occasion, making it easier for the patient to accept medical counsel.

LIBRARY

MAR 1 8 1974

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OF MEDICINE

for relief of excessive anxiety

ROCHE **Librium® 10-mg capsules**
(chlordiazepoxide HCl)

Please see reverse side for summary of product information.

The Nebraska Medical Journal

BALCONY

NEBRASKA
MEDICAL ASSOCIATION
106th Annual Session
APRIL 28 - - MAY 1, 1974
OMAHA HILTON
OMAHA, NEBRASKA

April, 1974

This psychoneurotic often responds

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

When you determine that the depressive symptoms are associated with or secondary to predominant anxiety in the psychoneurotic patient, consider Valium (diazepam) in addition to reassurance and counseling, for the psychotherapeutic support it provides. As anxiety is relieved, the depressive symptoms referable to it are also often relieved or reduced.

The beneficial effect of Valium is usually pronounced and rapid. Improvement generally becomes evident within a few days, although some patients may require a longer period. Moreover, Valium (diazepam) is generally well tolerated. Side effects most commonly reported are drowsiness, ataxia and fatigue. Caution your patients against engaging in hazardous occupations or driving.

Frequently, the patient's symptoms are greatly intensified at bedtime. In such situations, Valium offers an additional advantage: adding an *h.s.* dose to the *b.i.d.* or *t.i.d.* schedule can relieve the anxiety and thus may encourage a more restful night's sleep.

symptom complex to Valium® (diazepam)

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Valium® 2-mg, 5-mg, 10-mg tablets
(diazepam)

The Nebraska Medical Journal

EDITOR — FRANK COLE, M.D., 1845 "F" St., Apt. 1, Lincoln 68508
PHONE 475-3637

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JAMES L. BOYER, M.D.

May 1 Symposiums at your NMA Annual Session

WHAT'S NEW IN HEPATITIS will feature the Director of the Liver Study Unit at the University of Chicago Department of Medicine, James L. Boyer, M.D. along with John B. Byrd, M.D., of Kimball. Michael F. Sorrell, M.D., Omaha, will participate in and moderate this Symposium.

Dr. Boyer's major research interests consist of studies in the pathogenesis of acute and chronic liver injury and physiologic mechanism of bile secretion and biliary transport. He is an Associate Professor of Medicine at the Pritzker School of Medicine, Billings Hospital in Chicago.

What's New in Medicine

Symposium of What's New in Medicine deals with round table discussions on the "Little Problems With Big Consequences."

Topics include: Investments, Hand Injuries, Obstetrical Problems, Cardiac-Arrhythmias, and Fracture Clinic.

Nineteen Nebraskans offer some new outlooks for you at the May 1st afternoon symposium at your NMA Annual Session.

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Diagnosis of Gilbert Syndrome: Role of Reduced Caloric Intake Test — D. Owens (Nuffield Unit of Medical Genetics, Liverpool, England) and S. Sherlock. Br Med J 3:559-562 (Sept 15) 1973.

The effect of a reduction in caloric intake to 400 calories/day on the plasma bilirubin concentration was studied over a 72-hour period in subjects with Gilbert syndrome, liver disease, or hemolytic anemia and in normal controls. In normals and in those with Gilbert syndrome, there was a significant increase in the bilirubin concentration within 24 hours after reducing the caloric intake due to an increase in unconjugated pigment. There was no significant increase in the bilirubin concentration in the patients with liver disease and hemolytic anemia. An increase of 100% or more suggests that unconjugated hyperbilirubinemia is due to Gilbert syndrome. In the normal subjects, the unconjugated bilirubin level did not exceed 1.0 mg/100 ml.

The post-T&A patient:
another type for Tylenol
(acetaminophen)

When the post-T & A patient
equires an analgesic, a new prob-
em arises. Hemorrhagic tendencies
ollowing the use of aspirin after
onsillectomies have been reported.[1,2]
n a patient who "...has recently
undergone a surgical procedure or
has another underlying hemostatic
defect, aspirin ingestion may cause
ignificant bleeding....Aspirin is
bsolutely contraindicated in such
ituations. Acetaminophen...could
eplace aspirin in these instances."[3]

The post-T & A patient is only
one of several 'types for TYLENOL'—
that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Reuter, S. H., and Montgomery, W. W.: Arch. Otolaryng. *80*:214-217 (Aug.) 1964. 2. Osol, A., et al., ed.: The United States Dispensatory and Physicians' Pharmacology, ed. 26, Philadelphia, J. B. Lippincott Co., 1967, p. 171. 3. Schwartz, A. D., and Pearson, H. A.: J. Pediat. *78*:558-560 (March) 1971

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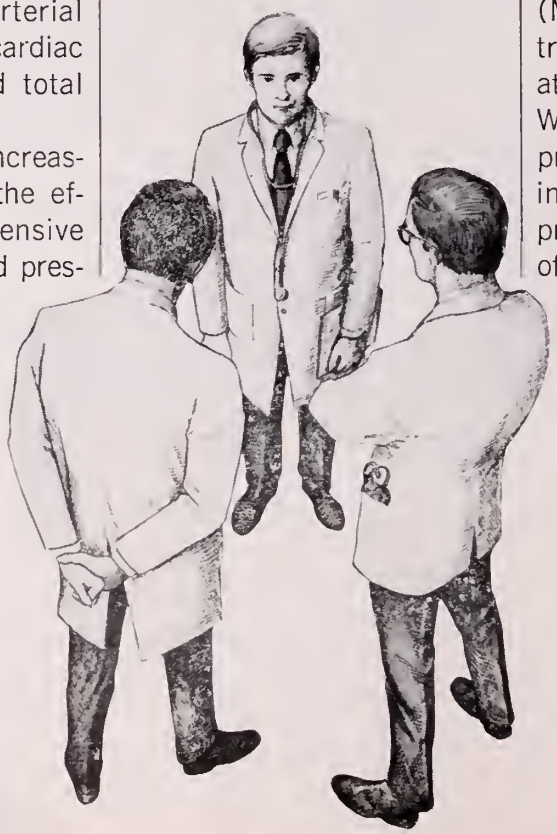
The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

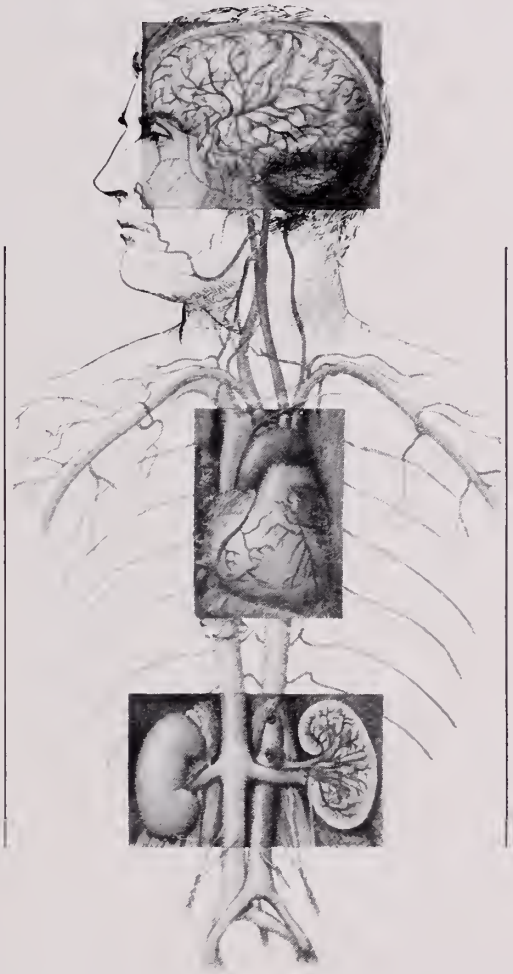
And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?

With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in



the more physicians rely on this unique antihypertensive



lowering blood pressure. But there are other considerations as well. Cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is actually slowed. Peripheral resistance is apparently reduced. ALDOMET does not usually compromise existing renal function; it generally does not reduce renal blood flow, glomerular filtration rate, or filtration fraction. And ALDOMET usually does not cause symptomatic postural or exercise hypotension.

Some patients on continuous methyldopa therapy may develop a positive direct Coombs test. For more details, see the brief summary of prescribing information.

Contraindicated in active hepatic disease and known sensitivity to the drug. Not recommended in pheochromocytoma or pregnancy. It should be used with caution in patients with a history of liver disease or dysfunction. Discontinue the drug if fever, abnormal liver function, jaundice, or acquired hemolytic anemia occurs.

In most cases of sustained moderate hypertension

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smoothly lowers blood pressure

For a brief summary of prescribing information, please see following page.

In most cases of sustained moderate hypertension

TABLETS, 250 mg

ALDOMET® (METHYLDOPA MSD)

smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: Acquired hemolytic anemia has occurred rarely in association with therapy with methyldopa. Should clinical symptoms indicate the possibility of anemia, hemoglobin and/or hematocrit determinations should be performed. If anemia is present, appropriate laboratory studies should be done to determine if hemolysis is present. Evidence of hemolytic anemia is an indication for discontinuation of the drug. Discontinuation of methyldopa alone or the initiation of adrenocortical steroids usually results in a prompt remission of the anemia. Rarely, however, fatalities have occurred.

Some patients on continued therapy with methyldopa develop a positive direct Coombs test; incidence reported has averaged between 10% and 20%. It rarely occurs in first six months of therapy, and if not seen within twelve months, is unlikely to develop with continued administration. Positive Coombs test is dose-related; lowest incidence occurs in patients on 1 g methyldopa or less per day. Reversal of the positive Coombs test occurs within weeks to months after discontinuation of methyldopa. Prior knowledge of a positive Coombs reaction aids in evaluation of cross match for transfusions. Patients with positive Coombs tests at time of cross match may exhibit incompatible minor cross match. When this occurs, an indirect Coombs test should be performed. If negative, transfusion with blood otherwise compatible in the major cross match may be carried out. If positive, advisability of transfusion with blood compatible in major cross match should be determined by hematologist or expert in transfusion problems.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rare cases of fatal hepatic necrosis have been reported. Liver biopsy in several patients with liver dysfunction has shown microscopic focal necrosis compatible with drug hypersensitivity. Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen; reversible agranulocytosis has been reported. Methyldopa may interfere with measurement of creatinine by alkaline picrate method and of uric acid by phosphotungstate method. When used with other antihypertensive drugs, potentiation of antihypertensive action may occur.

Usage in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Perform periodic hepatic function tests and white cell and differential blood counts during first six to twelve weeks of therapy or in unexplained fever. Discontinue if fever, abnormalities in liver function tests, or jaundice appears. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Discontinue drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Anesthetics requirements may be reduced; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension may occur after dialysis because methyldopa is removed by this procedure.

Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Do not exceed recommended daily dose of 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure, including dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency, are seen occasionally. Angina pectoris may be aggravated. Symptoms of orthostatic and exercise hypotension may occur; if symptoms occur, reduce dosage. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distension, constipation, flatus, and diarrhea occur occasionally; these can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently; if edema progresses or signs of pulmonary congestion appear, discontinue drug. Rarely, urine exposed to air may darken due to breakdown of methyldopa or its metabolites. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression, reversible thrombocytopenia, drug-related fever and abnormal liver function studies with jaundice and hepatocellular damage (see **Warnings** and **Precautions**), rise in BUN, and a single case of bilateral Bell's palsy.

Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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ADDENDUM

Let's make blood pressure "required reading" for all physicians.

With recent estimates that about 23 million Americans have high blood pressure—and that half of them are not even aware of it—detection of the problem in asymptomatic persons has become an issue of national importance.

Family physicians are being urged to take blood pressure readings as a matter of office routine, regardless of the presenting complaint or the reason for the visit. And because many people do not see a family physician for relatively long periods of time, some experts are suggesting that ophthalmologists, gynecologists, dermatologists, orthopedists, psychiatrists, dentists, school nurses, family planning counselors, and other health-care personnel make blood pressure reading a routine part of every examination or consultation.

Of course, a diagnosis of hypertension cannot be made on the basis of a single reading, but routine blood pressure readings can uncover potential trouble in a certain proportion of patients. And when trouble is suggested, further evaluation can be pursued more effectively.

Blood pressure—"required reading" for all physicians.

Late Results After Femoro-femoral Venous Bypass in Unilateral Chronic Pelvic-Vein Thrombosis — H. Ehringer et al (Medizinische Universitatsklinik, Vienna). Dtsch Med Wochenschr 98:1951-1955 (Oct 19) 1973.

Venous hemodynamics were measured by directional Doppler ultrasound and compared with phlebographic findings in ten patients with unilateral chronic pelvic-vein thrombosis who had a Palma operation performed an average of 46 months previously. The thrombosis had been present in this group for an average of 23 months. Palma operation consists of transverse suprapubic implantation of a saphenous vein bypass from the unaffected side to the sapheno-femoral junction of the affected side. In seven of the ten patients the venous flow proceeded from the diseased to the normal side and with normal pressures (respiratory swing with inspiratory stop) in six of them after the Palma operation. In one patient recanalization of the pelvic veins was demonstrable.

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What's on your patient's face...

may be more important than his chief complaint

Patient P.T.* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.

Patient P.T.* seen on 6/12/67, seven weeks after discontinuation of 5% FU cream. Reaction has subsided. Residual scarring not seen except that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J

The lesions on his face are solar/actinic— so-called "senile" keratoses... and they may be premalignant.

Solar, actinic or senile keratoses

These lesions may be called by several names, but they usually can be identified by the following characteristics. The typical lesion is flat or slightly elevated, of a brownish or reddish color, papular, dry, rough, adherent and sharply defined. They commonly occur as multiple lesions, chiefly on the exposed portions of the skin.

Sequence of therapy— selectivity of response

After several days of therapy with Efudex® (fluorouracil), erythema may begin to appear in the area of the lesions; this reaction usually reaches its height of unsightliness and discomfort within two weeks, declining after discontinuation of therapy. This reaction occurs in affected areas. Since the response is so predictable, lesions that do not respond should be biopsied.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

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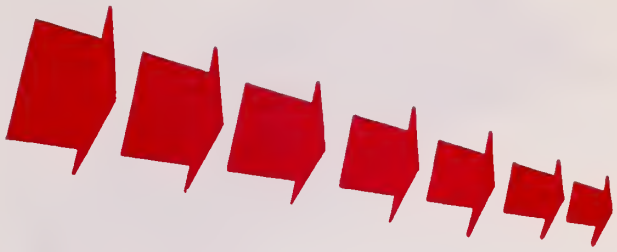

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Letters to the Editor submitted for publication should be prepared as above, and must carry the notation: To be Published.

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Incidence of Acute and Chronic Hepatitis Among Members of Medical Profession — E. Kownatzki (Medizinische Universitatsklinik, Freiburg, West Germany). Med Klinik 46:1511-1514 (Nov 16) 1973.

The number of members of the medical profession was determined among patients with acute and chronic hepatitis. Among the general population the incidence of acute infectious hepatitis was 0.05%. Among medical workers this figure was 0.8%, or 16 times as high. The incidence of chronic hepatitis was comparable in both groups. This difference raises a question of possibly different etiology of these two diseases.

Before and After Dialysis Urography — J. A. Becker (State Univ of New York, Downstate Medical Center, Brooklyn 11203). Radiology 109:271-275 (Nov) 1973.

Twelve patients receiving chronic dialysis treatment were studied to determine the effect of dialysis on visualization of the pelvocaliceal system. Patients received injections of contrast material before and after dialysis. Dialysis enhanced visualization in one patient; however, no patient showing nonvisualization of the pelvocaliceal system prior to dialysis showed visualization afterward.

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These professional and trade organizations are united in supporting antisubstitution statutes and regulations:

The American Academy of Dermatology

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The National Wholesale Druggists' Association

int Statement on Antisubstitution Laws and Regulations

The purpose of this statement is affirm the support of the participat- g organizations for the laws, regula- ons and professional traditions which ohibit the unauthorized substitution drug products.

Traditionally, physicians, den- sts and pharmacists have worked operatively to serve the best inter- ts of patients. Productive coopera- n has been achieved through utual respect as well as a common ncern for the ideals of public rvice. This mutual respect has been flected, in part, by joint support er the years for the adoption and forcement of laws and regulations ecifically prohibiting unauthorized bstitution and encouraging joint scussion and selection of the urce of supply of drug products. e basic principles of medical, den- and pharmacy practice are thus ilized and preserved in the interest patient welfare.

The antisubstitution laws have t obstructed enhancement of the ofessional status of pharmacy any ore than they have in and of them- lves guaranteed absolute protec- n from unsafe drugs, or freed ysicians, dentists and pharmacists m their responsibilities to patients. a practical matter, however, such ws and regulations encourage inter- ofessional communications regard- g drug product selection and assure ch profession the opportunity to ercise fully its expertise in drug age, to the advantage of patients.

Physicians and dentists should urged to increase the frequency d regularity of their contacts with armacists in selection of quality ug products, recognizing that economies to patients can be im- proved through such communica- tion, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physi- cians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selec- tion remain primary and do not per- mit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved under- standing and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthor- ized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

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THE NEBRASKA MEDICAL JOURNAL

DOES IT HURT TO BE BORN? DOES IT HURT TO DIE?

As the good book says, you cannot grow taller by thinking about it, although short actresses have played queens. And dwelling on a subject, what with pouring money down bottomless pits, will not solve problems unless sense is mixed with the grants-in-aid. All of this brings me easily to my thesis that no one can tell you what it feels like to be born or to die, and if we study the question for many years and as many dollars, we are not likely to come up with an answer.

But one can always guess. This involves little effort and no expense; one has only to look at those who are breathing their last. This requires a great deal of time, and even then the study may be fruitless. Dying patients are often sedated and as commonly unconscious, and generally uncommunicative.

In a wonderful experiment, someone who was about to be beheaded was asked by a friend if he would try to wink the moment his head was off, but I forget the end of the story.

The neonate is crammed full of life, like sawdust in a rag doll, but it has all run out of the dying person.

Being born is traumatic, and babies cry to tell us so. The mother is anesthetized for childbirth, but the child is not. Yet so much is inflicted on the just-born: witness awake endotracheal intubation, circumcision, and surgery with inadequate anesthesia or without any; all on the unsupported theory that infants are too young to feel pain. Some have turned to psychoanalysis or to hypnosis for an answer, without success.

We may one day come up with new techniques of communicating with the newborn and with the dying; now we can only think about it and guess, but thinking is not knowing, and we cannot think ourselves tall, or thin.

—F.C.

WHY DOES MEDICINE COST SO MUCH?

I had breakfast out twice this week, you will be glad to know: bacon and eggs and coffee. Coffee was 20 cents in one place and 25 cents in the other; I think I can make a cup for about 3 cents. One egg was 40 cents in the first restaurant and it was 65 cents in the second, *one egg*. You can buy an egg for 6 cents in the grocery store.

Congressional salaries were raised from $30,000 to $42,500, which is a very nice raise, and I think they raised their own salaries, which is a nice arrangement. The President's salary went from $100,000 to $200,000, which is even nicer.

And baseball players have just signed contracts paying $150,000 and $172,500; I think it's for *one year*.

Let's see; 65 cents an egg comes to $7.80 a dozen, which I can hardly bring myself to say. And as for $172,500 a year: I should have studied throwing a ball.

People could eat out oftener if eggs didn't cost $7.80 a dozen, plus the tip. And they could go to more ball games if they didn't have to contribute to $172,500 salaries.

But medicine now, well, you get my point.

—F.C.

I KNOW WHAT I WILL DIE OF

The death certificate is not one of our nobler documents. The cause of death is often guessed at by someone who was not there, and without the benefit of autopsy. If death came suddenly, it is commonly ascribed to a heart attack, with no other evidence.

But if someone dies of multiple sclerosis or of leukemia, the certificate does not generally say so. Instead, it says that the patient died because of cardiorespiratory arrest, and the disease that really killed him is given as a contributory factor. So cardiorespiratory arrest appears on many of these forms.

Where it does not belong.

Because everybody dies of cardiorespiratory arrest. It just means that your heart stopped beating and you stopped breathing. And everybody's heart stops beating and everybody stops breathing when he dies.

So that is what I will die of.

Cardiorespiratory arrest. There's a lot of it going around.

I hope it is brought on by a pleasant old age, though.

—F.C.

DOCTORS AND THE LAW

I have several quarrels with the law, with lawyers, that is; one of them is their contingent fee basis, and another is res ipsa loquitur. There are other differences between us; we have as many books in our library as they, we just don't have time to read them in the middle of an operation.

But they make decisions and then they reverse them. If we enjoyed the privilege given to the lawyers, it might go something like this. We decided that you just had an upset stomach, but the decision was reversed by a higher clinic, and they decided you have appendicitis, so we will operate.

Or we decided that you had cancer and needed to have tests, but the decision was reversed by a superior group, and they decided that you're a malingerer, and we're sending you home.

Sometimes the reversal gets reversed, which is funny, except that if the lawyers were in the operating room, their patients would be dead.

What I am talking about is malpractice, which is a bad term anyway, and should be replaced by something like physician insurance. The attorney can decide his client is innocent while the court decides he is guilty, but they don't sue the lawyer for making a wrong decision. And a higher court may reverse the judge's decision, and nobody sues the judge.

I suggest that they sue lawyers and judges, or that they stop suing the doctors. And who is suing the doctors? The lawyers. Maybe the doctors ought to sue the lawyers.

—F.C.

SHOULD MEDICAL BOOKS BE FREE?

Books are life-savers, but they are not free, so that a physician may be without them during an emergency. And a life may be lost for want of money. Since the government is doing so much these days, I suggest that it ease the doctor's burden and supply him with all medical books without charge.

Doctors would have books they need when emergencies strike, they would have larger and better libraries, they would be better read, and they would be well informed. They would be better doctors, and that is what the government wants, or it is what the government should want.

Instruments should be free, too.

—F.C.

WATER AND IRON

I had a dental block for a filling because I am not quite a monument of courage, and an hour later I found myself confronting a hostess in one of our nicer food establishments. I told the officialette of my insensitive lip; I said that my laughingly-called friend, the dental ogre, had advised me to eat blue soup so it would match my suit, since my table manners were not about to be at my best and I was sure to dribble or drool, whichever comes first. The stewardess heard only that I hurt, whereupon she promptly prescribed a glass of water.

When someone has fainted, and they don't faint as much as they used to, a bystander always calls for a glass of water, besides ordering the other onlookers to stand back and give him air, as if there were not gobs and gobs of it around.

When something has gone down the wrong way, misled witnesses will force a glass of water on you; and they will do the same

when for some reason you cannot get your breath momentarily.

Water is a fine drink, especially when flavored, but I do not know how all of this got around, about a glass of water being a panacea for all common emergencies. And I doubt that it is the specific remedy it is said to be; not for near-drowning surely.

When they weigh the elements to determine molecular weights, I wonder if they remember that in the case of iron, the force resulting from the magnetic attraction between the iron and the earth is added to the force of gravity, if the relativists will let me use those words, so that for iron, the weight shown on the scale is too high. I wish I had thought to tell this to Dr. Einstein, but then he wasn't a real doctor.

He might have offered me a glass of water.

—F.C.

SPRING HAS SPRUNG

I forget what the groundhog said, but the television temperature and the telephone tape told me, after I added their numbers and divided by two, that it was spring, and all of this without looking out of the window.

So I shed my coat and went out and walked. And I saw boys playing baseball, what I think is crocus, a cardinal, a yellow weeping willow, boys flying kites, dogs playing, a robin, boys playing basketball, boys lying on lawns, something I called forsythia, cars getting washed, squirrels, girls walking, tricycles and the bluest sky I have ever seen.

It's spring, and young men's fancies are turning to what the girls have been thinking about all winter, and the old-timers recommended sulphur and molasses.

The buds will bud and the sap will rise, and it makes you think about the wonder of it all. Don't people say I saw my first robin anymore? Well, I did.

—F.C.

Flower Vases in Hospitals as Reservoirs of Pathogens — D. Taplin (Univ of Miami School of Medicine, Miami, FL 33152) and P. M. Mertz. Lancet 2:1279-1281 (Dec 8) 1973.

Flower vases in surgical wards and a burn unit in two Miami hospitals carried large numbers of potentially pathogenic bacteria in the water they contained. Bacterial counts reached 1×10^{13} colony-forming units (CFU)/ml within three days of placing flowers in clean tap water. Counts of gentamicin-resistant bacteria in flower vases found in surgical wards reached 8 million CFU/ml of flower water. Among the species identified were *Pseudomonas aeruginosa, P cepacia, P alcaligenes, Aeromonas hydrophila, Acinetobacter* spp, *Flavobacterium* spp, *Escherichia coli, Klebsiella ozaena,* and *Proteus mirabilis.* Six of these species have previously been reported to cause hospital infections.

Bell Palsy —K. K. Adour et al (280 W McArthur Blvd, Oakland, CA 94611). Arch Otolaryngol 99:114-117 (Feb) 1974.

In a study of 395 patients with Bell palsy, which includes only those patients having a single episode of facial paralysis, 6.4% were known to have diabetes mellitus. The two-hour postprandial blood glucose value, measured in 232 consecutive unselected members of the study population, was 120 mg/100 ml or higher in 54 (23.3%). In these 54 patients, glucose tolerance was tested (in those receiving prednisone, one month after completion of therapy). Ten (4.3% of 232) showed chemical or overt diabetes. Among untreated patients, 45% of nondiabetic and 76% of diabetic subjects showed clinically complete paralysis; 20% of nondiabetic and 53% of diabetic patients showed complete or partial muscle denervation.

"My diseases are an asthma and a dropsy and, what is less durable, secenty-five."

Samuel Johnson

Interstitial Gastric Emphysema: A Case Report

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and
ABRAHAM MELAMED, M.D.†

ABSTRACT

An unusual case of interstitial gastric emphysema associated with eventration of the right hemidiaphragam and gastric volvulus is presented. Increased intraluminal pressure secondary to the volvulus and mucosal erosion from a nasogastric tube are discussed as possible mechanisms for origin of the interstitial air.

THE discovery of air within the wall of the stomach during a roentgen study of the abdomen is an uncommon occurrence and indicates underlying pathology. Mucosal ischemia, inflammation, ingestion of corrosive substances and increased intraluminal pressure have all been implicated.[6] The configuration of interstitial air may vary from curvilinear to cystic radiolucenceeis. Three separate classifications of air within the gastric wall are now commonly accepted: emphysematous gastritis, cystic pneumatosis, and interstitial (intramural) gastric emphysema. The roentgenologic and clinical characteristics of these entities have been presented in the literature in recent years by Seaman,[6] Brens,[1] Isdale,[3] and Nelson.[4] The purpose of this report is to present an unusual case of interstitial gastric emphysema associated with eventration of the right hemidiaphragm and gastric volvulus.

Case Report

A 46 year old white male was admitted to the hospital with severe mid-abdominal pain of four hours duration. Intermittent vomiting had been present for one month before admission becoming so severe that he was unable to retain solid food. A duodenal ulcer had been diagnosed one year ago. Other past medical history was not contributory except for the knowledge that roentgen studies seven years ago had shown eventration of the right hemidiaphragm containing herniated colon and stomach.

Physical Examination. The patient was emaciated, dehydrated and in acute abdominal distress with a pulse of 130 per minute, blood pressure 100/88, and temperature of 99.4° F. His abdomen was rigid and tender, with a bulging epigastrium. No bowel sounds were heard. Scoliosis of the dorsal and lumbar spine was noted. Blood chemistries indicated a metabolic alkalosis. His hemoglobin was 17.0 grams percent; white blood count 12,000, with 81 neutrophils, 14 lymphocytes, 4 monocytes and 1 eosinophil. The clinical impression was perforated peptic ulcer with metabolic alkalosis. Appropriate intravenous fluids were given. A nasogastric tube was passed into the stomach without difficulty, and 400 ml of black fluid were aspirated. The nasogastric tube was retained in the stomach for three days.

Roentgen Findings. An admission chest film showed eventration of the right hemidiaphragm. Lateral decubitus views of the abdomen showed no evidence of extraalimentary air or intestinal obstruction. A supine view of the abdomen taken five days after admission (Fig. 1) disclosed the presence of air in a curvilinear configuration located in the right lower hemithorax. This was interpreted as air within the wall of the herniated stomach. This

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interpretation was confirmed when a barium meal examination was performed one day after the plain film studies of the abdomen. The patient was afebrile at this time. An organo-axial volvulus of the herniated stomach was present with intramural air distributed along the greater and lesser curvatures of the body and antrum (Fig. 2). A 24 hour delayed film demonstrated a herniated segment of colon anterior to the stomach.

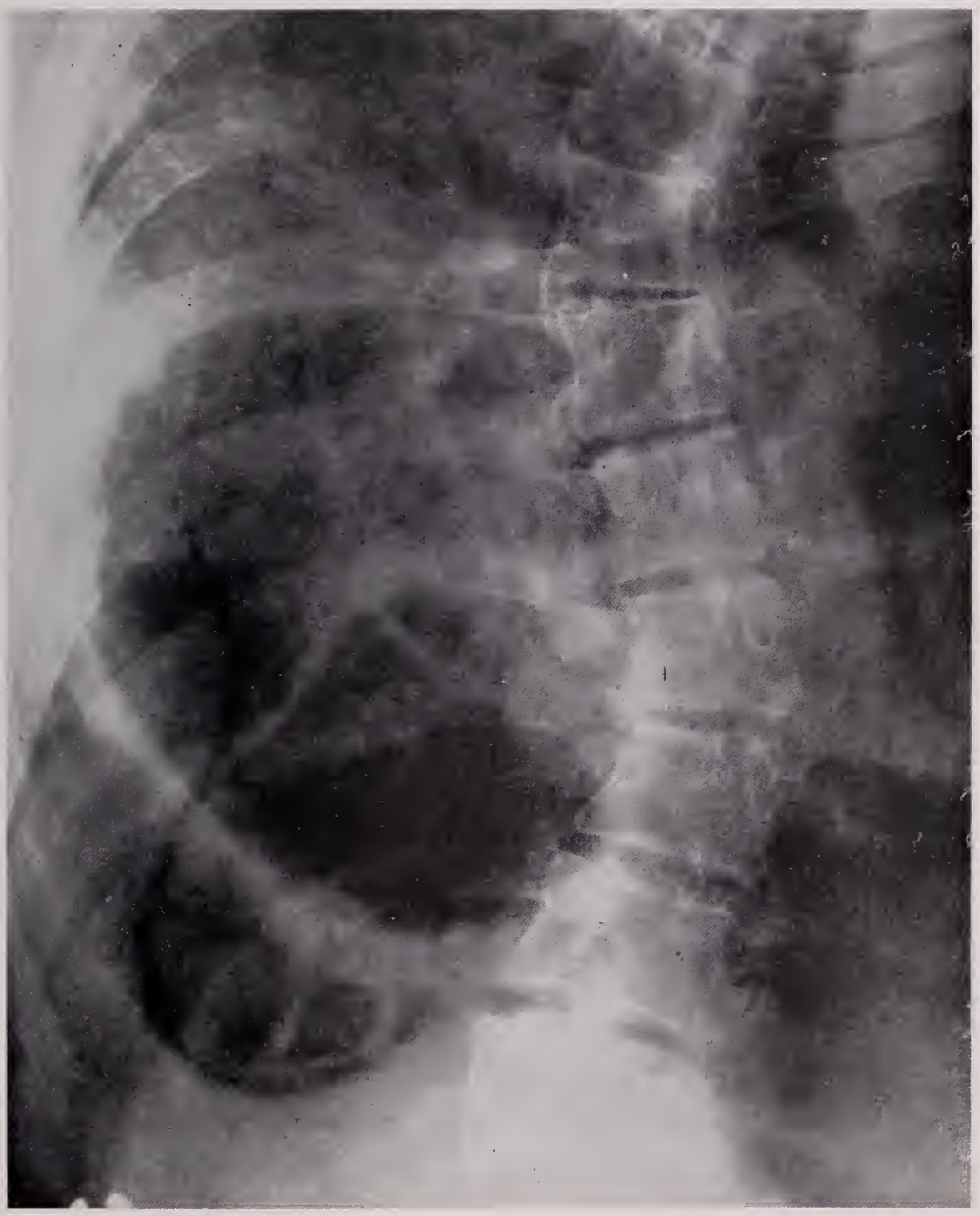

Figure 1. A supine view of the abdomen shows air in the wall of the volvulated stomach under the right hemidiaphragm. Scoliosis of the dorsal and lumbar spine is present.

Figures 2-A and 2-B. Upright anterior-posterior (A) and lateral (B) views of the abdomen taken after a barium meal study show an organo-axial volvulus of the stomach. The gastric interstitial air is more precisely defined. A small amount of barium is seen within the descending and transverse portions of the duodenal loop.

Figure 2-B

The patient did not wish surgery and was discharged 16 days after admission, improved and able to eat a soft diet. He was admitted again within 48 hours with the same symptoms. Again he was discharged after responding to conservative therapy. Three weeks later he was admitted for the third time with the same signs and symptoms. He finally consented to surgery. No roentgen studies were obtained during the second and third admissions.

Surgery. Eventration of the right hemidiaphragm was found accompanied by a large, dilated volvulated stomach. A segment of transverse colon was located anterior to the stomach. A deformed duodenal bulb was present without evidence of an active ulcer crater. The gastric volvulus was corrected and an anterior gastroenterostomy was performed. The stomach was then attached to the parietal peritoneum.

The patient was released 14 days after admission and has had no recurrence of abdominal pain or vomiting during the eight years since discharge.

Literature

Seaman and Fleming reviewed the literature in 1967 and found only 15 cases of intramural gastric emphysema.[6] Isdale in 1970 found 19 more cases in the literature and added one of his own.[3] Nelson in 1972 reported a case of interstitial gastric emphysema secondary to the ingestion of formaldehyde.[4] Thus, we are aware of a total of 36 cases reported in the literature up to 1973. We could find only one case, reported by Seaman and Fleming, that was associated with gastric volvulus.[6]

Discussion

The patient's prolonged vomiting and acute abdominal pain were most likely related to the gastric volvulus.[5] Since no active duodenal ulcer was found, it is doubtful that ulcer disease played a role in the acute symptomatology. The distribution of interstitial air was limited to the antrum and body of the stomach along the lesser and greater curvatures. There was nothing in the patient's history or medical evaluation to suggest an underlying cause such as instrumentation, bacterial inflammation or ingestion of a corrosive substance. Therefore, the etiologic mechanism for the formation of the intramural air was most likely on a mechanical basis as described by various authors.[1, 4, 6] Partial or complete gastric outlet obstruction temporarily resulted from the volvulus. The obstruction in turn caused elevation of the intraluminal air pressure which was further increased by vomiting. Intraluminal air could then have been forced intramurally through the gastric mucosa which had been damaged by the distention. It is also possible that the nasogastric tube caused a tiny erosion in the distended mucosa which served as an exit point for the air into the gastric wall. Since no active ulcer was found this potential avenue of escape for intraluminal air can be disregarded.[2]

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American Lung Association of Nebraska: A New Name for the Christmas Seal Association

DELMAR R. SERAFY, M.A.
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IRVING KASS, M.D.

THE American Lung Association is the new name for one of the oldest national health agencies. The organization was founded in 1904 and its original purpose was to control tuberculosis. Until 1918 it was known as the National Association for the Study and Prevention of Tuberculosis. In 1918 the name was changed to the National Tuberculosis Association. The organization operated under that name until February, 1968, when the name was changed to reflect a broadening in its respiratory interests. For the last five years the agency has been known as the National Tuberculosis and Respiratory Disease Association. The new name, American Lung Association, is not only more convenient but it reflects the major purposes of the agency namely the prevention and control of lung diseases. The red double barred cross, however, will continue as the Association's symbol.

The Nebraska affiliate changed its name in June, 1973. The new name is the American Lung Association of Nebraska. The Nebraska organization was founded in 1907, just three years after the founding of the National organization and its name change pattern has been similar to that of the National association.

From 1911 until its closing in 1972, the Nebraska Tuberculosis and Respiratory Disease Association worked very closely with the Nebraska State Hospital for the Tuberculous in the care of individuals ill with that disease. Following the closing of the State Tuberculosis Hospital, the state organization has cooperated with the Nebraska State Health Department in the development of a new program to provide care for the tuberculous patient. Because of treatment programs developed in part by the American Lung Association, modern treatment of tuberculosis now requires but a short stay in a general hospital, just long enough to confirm that the patient is responding well to his antituberculosis therapy. Following dismissal the patient continues the chemotherapy under medical supervision as an outpatient for a period of at least 18 months.

The Nebraska Association began its interest in other respiratory diseases prior to its name change in 1968 from the Nebraska Tuberculosis Association to the Nebraska Tuberculosis and Respiratory Disease Association. This was perfectly logical because the governing board had approximately 25% of its membership made up of physicians who were interested not only in tuberculosis but in other respiratory diseases.

In 1966 one of the most important steps taken by the Nebraska Association in its expansion into other respiratory diseases was to subsidize for a period of six years the salaries of two faculty members. This enabled the University of Nebraska College of Medicine and the Creighton School of Medicine to recruit new and/or additional physicians with a background in Pulmonology. As the result of this program Dr. Irving Kass developed a Division of Pulmonology at the University of Nebraska and Dr. Robert Townely joined an existing Division at Creighton University. Through their efforts both schools gave a more prominent place to respiratory diseases in their curriculum. The presence of additional faculty members interested in pulmonary diseases has heightened the interest of the citizens of this state in respiratory diseases and recently Mr. Arthur E. Larson, Lincoln, Ne-

braska, endowed a Professorship in Respiratory Diseases at the University of Nebraska in memory of his wife, Margaret E. Larson, who suffered from a chronic respiratory problem. Dr. Kass has been appointed as the Larson Professor in Internal Medicine.

For years the Nebraska Association assisted with the financing of research by submitting funds to the National Association which were added to its nationwide pool for funding research activities. In more recent years, the Nebraska Association has funded research activities in respiratory disease at both of the medical schools. Currently, there are five projects that are being supported. At Creighton University these projects are under the direction of Alfred W. Brody, M.D., D.Sc.; Guillermo V. Villacorte, M.D.; H. M. Guirgis, Ph.D., and Ibert C. Wells, Ph.D.; and at the University of Nebraska a project is headed by William E. Dye, Ph.D. A sixth project, referred to as a service project, is being conducted under the supervision of Robert G. Townley, M.D., at Creighton University.

A recent review of the expenditures of the Christmas Seal funds for research originating in the two medical schools showed that the total granted from 1961 to date is $135,073. Included in this funding is the development of a Reference Mycobacteriology Laboratory at the University of Nebraska, and the purchase of a Zeiss II Photomicroscope for a Sputum Research Laboratory at the same school. In the past the Nebraska Association has supported such activities as studies designed to test the effectiveness of pursed-lip breathing in the treatment of patients with chronic obstructive pulmonary diseases (COPD); the frequency of COPD in rural Nebraska; and the detection of subjects with COPD at the 1970-71 State Fairs. In the latter instance (a scientific first) a computer was used to analyze "on-line" the changes in the maximal expiratory flow-volume curve. Other research projects include studies in asthma and in pulmonary function testing standardization.

The Nebraska Association has also been active in funding educational projects in respiratory disease at both medical schools as well as throughout the state. It has supported postgraduate training courses in respiratory diseases; attending of the annually held Boston Course on Pulmonary Functions by one Fellow in Chest Diseases from each medical school; support for faculty attending the Emphysema Conference in Aspen, Colorado; funding for physicians and nurses attending the tuberculosis training courses offered at either the Center for Disease Control, Atlanta, Georgia or National Jewish Hospital, Denver, Colorado; and training of laboratory technicians in the examination of the serum in patients with COPD for the presence of a genetically determined lung protective substance. Workshops on tuberculosis for nurses in Nebraska have also been supported. Since 1963, the total allocated for medical education is $79,675.

Environmental factors which affect the lung have become a matter of concern and the Association has added an educational program about the effects of air pollution and the dangers of cigarette smoking. Along with the other volunteer health agencies the Nebraska Tuberculosis and Respiratory Disease Association has sponsored numerous Quit-Smoking Clinics. The Association is now interested in developing an Emphysema Club so that individuals with this disease could draw mutual support from one another. The Association supports these public education programs because it operates on the concept that if an individual understands the significance of his respiratory disease he would more correctly present himself to his physician for a diagnosis and would respond more cooperatively with his physician in the treatment program.

Funds for the Association come from the Annual Christmas Seal Campaign. The Association is governed by a board of directors whose membership comes from communities widely scattered throughout Nebraska. The immediate affairs of the Association are governed by the executive committee, which includes five officers and six other members. The current officers are: President — Dr. Max Fleishman of Omaha; 1st Vice-President — Mrs. George Robertson of Omaha; 2nd Vice-President — Mrs. Dorothy Ogden of Lincoln; Secretary — Mrs. C. R. Caley of Clarks; and Treasurer — Dr. Irving Kass of Omaha.

Patient Education of Diabetics In a Rural Family Practice*

WILLIAM J. ORIGER, M.D.†

IN outpatient medicine, it is not the physician, but the patient who ultimately determines the therapy regimen to be followed. The most astute diagnosis and the utmost modern therapy is lost if the patient alters or neglects the prescribed diet, activity, or medication.

The concept of patient education recognizes that the final responsibility for treatment lies with the patient, and strives to insure that the patient's decision about his therapy is made on a reasonable basis of fact. Many studies of both inpatients and outpatients show widespread lack of knowledge of patients about their disease and its treatment.[1] This lack of knowledge can adversely effect treatment.

The literature contains a number of articles concerning effects of education on diabetic patients. Stone[2] studied poorly controlled diabetics to ascertain the reason for their lack of control. He found the single most common factor was inadequate knowledge of the disease. Etzwiler[3, 4] explores diabetic education and concludes, "Proper control can be achieved only by well informed patients cooperating with interested and knowledgeable health personnel." Studies by Ellis[5] offer a contrary view. He found an inverse relationship between the knowledge of diabetics and the control of their disease. This suggests another factor is needed in addition to knowledge. Preston and Miller[6] (in studying patients with chronic, nonpainful disease), stressed the importance of both education and a doctor/patient relationship based on mutual respect.

These studies suggest effectiveness of patient education only when it is coupled with a strong doctor/patient relationship. Patient education that is used without such a relationship seems to be ineffective.

In order to be meaningful, the patient education must be in the language of the patient, not that of the physician. Several studies which have recorded patient/physician interaction indicate the physician usually uses a vocabulary too technical for the patient;[7, 8] such communications are incomprehensible to the patient and often frustrate rather than reassure the patient.

Two of the most commonly used methods of formal patient education are audio-visual presentations and use of printed material. In studying the use of pamphlets, Klein[9] suggested that this form of communication added little to patients' knowledge. Those patients who remembered the pamphlets best had already received the knowledge from other sources. Pamphlets failed to meet the main expectation of the patients for reassuring information from the physician. Visual aids seemed to be the most useful means of patient education. It must be emphasized that these are only aids and are not a substitute for personal efforts to communicate with the patient.

Much of the literature about patient education describes programs in large urban hospitals, teaching hospitals, or government hospitals such as those run by the Public Health Service or the Veterans Administration. The unspoken assumption is that these are the only places that such programs are possible. It is the contention of this paper that patient education is within the scope of a rural family practice. This paper will now describe a program of patient education for diabetics used in rural family practice.

The program was initiated in Auburn, Nebraska, a county seat community of 3,600. The town and county are served by a group

*Presented at the Nebraska Medical Center Student Research Day, May 8, 1973.

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of 3 physicians using a 44-bed community hospital. The author spent 8 weeks in the community sponsored by NOVA (Nebraska Opportunities For Volunteers in Action) program, an OEO sponsored effort for college and professional students to spend time in local communities. Initiation of an education program for diabetics was the result of this program. The educational program, written and illustrated by the author, consists of four sets of 35 mm slides with accompanying scripts and three demonstrations. The scripts and illustrations use a general vocabulary appropriate to the rural, middleclass population.

The first series consists of 18 slides and an accompanying script entitled, "Diabetes, What Is It?" This explains insulin deficiency, vascular complications, and those at risk for diabetes. It defines control of diabetes and explains methods used for obtaining control.

The second series of 12 slides is entitled, "Diabetic Diet, Why?" It explains carbohydrate metabolism in normals and diabetics, action of insulin and oral agents on carbohydrate metabolism, factors affecting blood sugar, and weight control.

The third series, "Diet, The Exchange System," 23 slides, explains the ADA Diet. This illustrates food groups, portion size, and sample meals using the exchange system.

The fourth series, "Hypoglycemia," uses 9 slides to define hypoglycemia, its causes, treatment, and prevention.

Three demonstrations are used without visual aids. These cover skin and foot care, insulin injection, and urine testing.

This program is carried out by a single hospital-based RN. The program has been used primarily on an individual basis, but it is adaptable to any size group. The program is given to inpatients at their bedside at the order of their physician. Outpatients, at the recommendation of their physician, make an appointment with the hospital nurse, and participate in the program using a hospital conference room. No charge is made for this service.

An audiovisual program was chosen as an attractive method of maintaining interest. Available audio-visual programs were prohibitively expensive, or required elaborate equipment. A slide show with written script can be used by persons without special training. Slides are easily and economically reproduced, and can be shown anywhere, requiring only a portable projector and a screen or blank wall. Using personal presentation rather than a recording allows greater individualization and encourages questions. This maintains the personal interaction between patient and nurse.

Using a series of short programs allows flexibility. The amount of material presented can be tailored to the patient's attention span. Certain segments may be omitted or repeated according to the patient's need. The program on Diet Exchange System has been used for nondiabetics who use this diet for weight control alone.

The patients who received this educational program were followed as outpatients and control of their diabetes monitored by following body weights and fasting blood sugar. This method of followup appraisal of a patient education program was chosen instead of knowledge testing, since this indicates the ability of the patient to use the information to control his disease.

The patients selected to receive this program were chosen by their physicians without defined criteria. The first 10 patients to undergo this educational program were followed by review of their medical records. Followup was available in 9 of the 10 patients.

The patients included 6 men and 3 women ranging in age from 14 to 75. Three were newly diagnosed diabetics: the others had the disease for an average of 6.9 years (range 1½ to 13 years). Treatment regimen included two on diet alone, three taking oral hypoglycemic agents, and four using insulin.

In evaluating fasting blood sugar and weight, the single juvenile diabetic will be considered separately to give more accurate data. The patients were followed for one to six months, with an average of 3.5 months. Of the adult diabetics, only one had a fasting

blood sugar in the normal range before receiving the educational program. The average fasting blood sugar was 201 mg% (range 86 to 285). At the last followup (April, 1973) this average was 115 (range 74 to 152) with three of the eight values in the normal range. The average decrease in blood sugar was 88.5 mg%.

Seven of the eight patients lost weight. (Only one had been losing weight prior to the program). Weight loss for the eight averaged 2.5 pounds per month, with an average weight loss of 6.5 pounds (range: gain of 2 pounds to loss of 14 pounds). The one patient who did not lose weight did decrease his fasting blood sugar from 285 to 118 over the five month followup period.

The juvenile diabetic, age 14, entered the hospital in ketoacidosis. He and his parents received the diabetes education while he was in the hospital. In the subsequent four months, all fasting blood sugars have been normal, insulin requirements have dropped from 24 to 8 units, and he has gone from 15 to 5 pounds under his ideal weight.

Although this is a small, uncontrolled sample, the consistency of results tend to reinforce the usefulness of diabetic education in a rural family practice. The program described is flexible, and requires neither special training of the personnel or expensive equipment. This is ideal for use in the rural community where diabetes education is only one of the many roles played by the hospital RN.

Summary

A literature review shows the benefits of patient education in increasing patient compliance. Factors influencing an educational program include the use of appropriate vocabulary and the existence of a positive patient/physician relationship.

An audiovisual diabetes education program by the author was initiated in a rural family practice. Followup of nine patients showed an average weight loss of 2½ pounds per month and a decrease in fasting blood sugar by an average of 88 mg%. All were better able to control their diabetes after receiving diabetic education than before and eight of the nine made an appropriate weight change.

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Heart of the Community

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Past President,
Nebraska Heart Association

THE year of 1972 for the Nebraska Heart Association concluded with its Annual Meeting at Kearney in May. The Annual Meeting directed itself to the task of how the Heart Association can help communities in Nebraska establish stratified systems of Emergency Care similar to that system developed in Lincoln, Nebraska.

Coronary Care Units have produced a 50 percent improvement in the in-hospital survival for patients with acute myocardial infarction. Communities like Seattle, Mason City, a segment of Manhattan in New York City, Miami, Charlottesville, and Lincoln, to mention a few have developed emergency care systems or mobile heart teams. Most of these communities now have from 2 to 5 years of experience in this endeavor. The American Heart Association and the National Research Council sponsored a recent conference in Washington, D.C., to establish National Standards in Cardiopulmonary Resuscitation and Emergency Cardiac Care. National figures indicate that approximately 400,000 people die annually from a heart attack with sudden death outside the hospital. Rarely is any out-of-hospital cardiopulmonary resuscitation or basic life support carried out to attempt to save any of these persons. However, successful out-of-hospital resuscitation has been accomplished in those few cities mentioned above. This varies from 25 to 50 percent success rate and has a 10 to 35 percent longterm survival rate. Thus, it is conceivable that if widespread public education in CPR together with community organization of emergency care systems were accomplished throughout the nation, many lives could be saved.

The Nebraska Heart Association adopted seven far reaching and significant resolutions at its annual meeting to promote widespread public use of cardiopulmonary resuscitation and to encourage other communities within Nebraska to utilize the Heart Association materials, supplies, and its members to develop Emergency Care Systems within their community.

The seven resolutions are as follows:

1. Be resolved that the Nebraska Heart Association endorse the Governor's Emergency Care Council and offer consultant services to the Council and Communities in and out of Nebraska concerning education, development, communications, transportation, medical legal and other aspects of emergency care systems within a community.

2. Be resolved that the Nebraska Heart Association cooperate with other groups and agencies to initiate and develop emergency care councils within geographic areas for the express purpose to study, develop and implement stratified systems of emergency care in those areas.

3. Be resolved that the Nebraska Heart Association would recommend that all persons in Nebraska hospitals be trained and re-trained in emergency cardiopulmonary resuscitation (Basic Life Support).

4. Be resolved that the Nebraska Heart Association should inventory and evaluate various emergency medical systems in cardiopulmonary resuscitation courses for content, quality and extent. In addition the association offers its expertise in upgrading the program.

5. Be resolved that the Nebraska Heart Association establish formal communication in all aspects with fire and rescue organizations and municipal governments in Nebraska. A letter should be sent to all municipal governments stating the resolutions adopted at the Annual Assembly and indicating all training materials and services

which the Nebraska Heart Association can provide.

6. Be resolved that the Nebraska Heart Association supply local communities with guidelines and materials to implement the establishment of training for basic life support and the procurement of equipment to accomplish this task.
7. Be resolved that the Nebraska Heart Association direct educational efforts to focus on the recognition of signs and symptoms of a heart attack to the public in order that emergency cardiac care procedures can be initiated promptly.

Please let the Nebraska Heart Association know how it can help you to reduce the astounding number of persons who die needlessly from a heart attack each year.

Biomedical Science and the Public Interest*

CHARLES C. EDWARDS, M.D.
Assistant Secretary of Health
U.S. Department of Health, Education, and Welfare

WHEN Dr. Shubik asked if I could attend these dedication ceremonies, I was delighted to be able to accept. It is an honor to be present at the dedication of the splendid new Eppley Hall of Science, which marks an important milestone in the history of this distinguished Institute. It is also a great pleasure to return to Nebraska, to the State where I was born and to the part of the country that holds so many warm personal memories for me.

I grew up in Kearney, Nebraska, where my father practiced medicine for some 30 years. Just the other day, someone asked me if my father was a surgeon. He wasn't. He had a general practice in those years, but he did a lot of surgery, and it was good surgery. I can vouch for that.

I went to school in Kearney during what were very difficult years— not difficult for me personally — but difficult for our whole country: the Nation's worst depression, its worst drought, a time when all of us had reason to worry about the future.

To be able to reflect on those years and see the progress that has been achieved despite hardships demonstrates to me something important about the strength and vitality of this Nation and its people, a strength and vitality that will never be destroyed by a Watergate.

And speaking of strength and vitality, I can assure the younger people in the audience that we had great football teams then as now. We had the Lloyd Cardwells, the Sam Francises, the Charlie Brocks, and the Elmer Dormans on the squads that the University of Nebraska fielded in those tough years. Although I did not attend this great university, I feel a kinship to it not only in the memories of those exciting years, but in the many friends of mine who have studied and taught here.

And so today, we dedicate a new addition to the growing capability of the University of Nebraska School of Medicine and the Eppley Institute, facilities that will help carry forward the distinguished work of both institutions in biomedical research and medical education.

In my judgment, we are witnessing today a splendid example of the way in which the public and private sectors of our society can join forces in pursuit of the knowledge with which to promote and preserve human health. Without doubt, this is an endeavor that commands and deserves the best that both public and private resources can devote to it. For surely there is enough to do to

*For presentation June 22, 1973, at ceremonies dedicating the Eppley Hall of Science, the Eppley Institute for Research in Cancer, Omaha, Nebraska.

fully challenge the best efforts of both sectors of the nation's health enterprise.

Yet, I cannot help feeling that those of us who have elected to devote our professional lives to science — in medicine, as well as in other fields — are facing a new set of challenges today that our predecessors — the people of my father's generation for example — did not really have to come to grips with. Science and scientists from ancient times have been compelled to justify their existence and defend their contribution to human understanding but I think we would be hard put to identify a time when science and technology were more surely on trial than they are today.

Renaissance scientists such as Copernicus and Galileo endured religious persecution because of their investigations and discoveries. Later, men like Harvey and Pasteur suffered the scorn of their scientific colleagues. And in our own times, atomic scientists have been the victims of criticism and vilification because they opened up a new field of knowledge and new avenues of power.

But today I think we find a somewhat different climate, at once more rational and more disturbing than what has come before.

Today it is not individual scientists or their discoveries that are being challenged.

Today science itself is on trial, and its judges are not Popes or the doubting members of Royal Academies. Science is being judged today by society, by the people who pay for it and expect a reasonable return on their investment. After many years of being more or less satisfied, society is now having second thoughts.

I doubt if anyone would willingly erase the knowledge that science has produced in the last five hundred years, or even in the last five. But the use to which some of that knowledge has been put raises serious questions in the minds of laymen and scientists alike.

Who foresaw that microbiology, chemistry, and public health could make possible the virtual eradication of communicable disease and by so doing lead to a population explosion that threatens to diminish the quality of life throughout the entire world?

Who foresaw that quantum mechanics could provide both an inexhaustible supply of energy and the means to instant extinction of all life on this planet?

Who foresaw that a generation of incredible progress in the biomedical sciences such as we have just witnessed would have no more than a minor effect on such health indicators as lifespan, mortality rates, and overall occurrence of disease?

No one anticipated these things. We only see them dimly now. But even that dim perception raises serious questions about the contribution of science to the quality of human life.

The fact is that all of science, including biomedical research, is being subjected to a public accounting such as has never before occurred. Those of us who plan and carry out extensive public efforts in the conduct and support of biomedical science, as well as in the application of scientific knowledge in the field of health, must bear a major responsibility to account for our stewardship of public funds and the public trust.

But the same kind of responsibility rests on those in the private and voluntary health domain. For there too the public has a vital and appropriate concern, not simply because billions of tax dollars are channeled into private and voluntary health efforts, but also because these activities exist first and foremost to serve the needs of the people.

I want to say a few words about one critically important aspect of this public accountability of science, because it seems to me that many people are developing some serious misconceptions about what the Federal Government is trying to do in this age of scientific accountability.

The level of Federal spending for health research in the Fiscal Year that begins on July first will be the highest in history — more than $2.1 billion. Federal tax dollars will pay for two-thirds of all health research

and development activities in the coming Fiscal Year.

Incidentally, in 1952, Federal funds also paid for about two-thirds of all health related research and development, but that year our total national expenditure in this area came to only about $200 million, far less than 10 percent of what it is now.

But as spectacular as that growth has been — and I am sure we would all agree it has been necessary as well as spectacular — I am more concerned with what we are doing with such a large sum that I am with the fact that we have allocated this vast amount of money to biomedical and related research.

Obviously, those of us who guide the Federal health effort have a great responsibility to see to it that the American people earn a reasonable return on their investment in health research. But at the same time, we know — everyone here knows — that research accomplishments are not for sale. You can't simply go into the research marketplace and order a cure for cancer, or cardiovascular disease, or schizophrenia.

Any scientist and anyone who has responsibility for the administration of a research program knows that he or she cannot even be sure what discovery or what line of investigation will lead to these kinds of breakthrough. They will come; I am confident of that. But they will unfold out of basic, fundamental research. And that can never be completely planned, programmed, or predicted.

But this is not to say that there is no room in biomedical science for what can be called targeted research — the kind of investigation that builds on fundamental knowledge and carries it forward as rapidly as human ingenuity and technology will permit.

Certainly the cancer field lends itself to a substantial application of this kind of investigation. Cancer virology and cancer chemotherapy have undoubtedly progressed to a point where large-scale, planned investigations are warranted and justified. The same is true I believe in the area of heart research.

This is not something that a handful of bureaucrats in Washington have decided. On the contrary, many of the most distinguished investigators in both the heart and cancer fields support the concept of programmed research in these fields. The major initiatives now being developed are the product of the most sober, careful, and reasoned analysis of where we stand in our efforts to make substantial progress against these two leading causes of death. And in the judgment of the distinguished scientists whose guidance we sought, it is appropriate now to launch major initiatives in cancer and heart disease that involve substantial investments in targeted research.

At the same time — and this point somehow tends to be lost in much of the discussion — we must maintain a very high level of support for what has come to be called investigator initiated research. By this I mean the kind of investigation — call it fundamental research if you will — that is not intended to fit into an overall plan aimed at a specific goal. It is research that probes the vast area beyond present understanding, where no one can predict the outcome or plan a large-scale applied research and development effort.

Unfortunately, some people have suggested that the Federal Government is abandoning basic research, giving up the research grant in favor of the research contract. Well that simply isn't the case. While we have made some adjustments in the allocation of biomedical research funds, we certainly have not turned our backs on basic research, nor do we have any plans to do so.

What we are seeking — what we must seek — is the kind of flexibility in the whole biomedical research enterprise that offers the greatest promise of continued progress. We must have the ability to select and pursue priorities — as the President has done in the field of cancer. But we must also keep open the many lines of research, any of which might lead to fundamental discoveries anywhere in the widening spectrum of scientific inquiry. No one knows where the path of biomedical research might lead or which avenue might open the way to major breakthrough. But

what we do know is that we need the capacity and the flexibility to follow the research paths open to us and to capitalize on major advances from whatever direction they come.

The conduct of biomedical research is, in a very real sense, the public's business. Here at Eppley Institute and in hundreds or thousands of other facilities throughout the country, the people's business is being attended to. I'll grant that this notion of science in the public interest is alien to many, and perhaps unacceptable to some. But it is true, and furthermore I think it is very beneficial.

In my judgment, the new accountability of science, far from being a threat, is perhaps one of the most important positive developments in the history of science. Accountability is making it necessary to explain scientific endeavors in terms that the public can comprehend. I am inclined to believe that the more the American people understand what research and technology can and cannot do, the greater will be their willingness to support scientific inquiry and to recognize its achievements and goals.

And on the other side of the coin, we who are involved in scientific endeavors should accept — I think willingly — our responsibility to the society of which we are a part. The era — and it has been a very long one — when science considered itself aloof from the concerns of society, or even above them, has come to an end. In its place is a time of trial for science, but also a time of tremendous opportunity — a time when the fruits of scientific inquiry can be turned wisely and effectively to help solve many of the great problems that confront mankind.

We are dedicating this new Hall of Science at a time when science is on trial, but also at a time when the prospects for advancement of human knowledge and the conquest of disease were never brighter.

I am proud and honored to be able to share with you the satisfaction of this occasion. And I am confident that this Institute and the University with which it is associated will continue to make an invaluable contribution to the conduct of biomedical research in the public interest.

My Fifty Year Medical Practice

D. O. HUGHES, M.D.

ON arriving in Fairbury I went to work for Drs. Potter, Birdsal and Harvey. My first introduction was to do a local tonsil with the three physicians watching me. Later the same afternoon, I was allowed to go and deliver a baby — in a double bed in the home (I was a lot smarter then than I am now). Home obstetrical cases were the order of the day, no one ever thought of going to the hospital for an obstetrical case, including delivering breech presentations, cross-ways, on a large feather bed.

House calls were also the order of the day. Including the time I was returning from a house call, I saw a man lying in the street. I immediately stopped my car and jumped out to help aid and assist him. I found that he had been shot and that the First National Bank in Fairbury was being robbed. I thought all the noise was due to an automobile back-firing but found that it was bullets being shot over my head and around me. This robbery was being accomplished by Ma Barker and her boys. Part of the money and the non-negotiable bonds were recovered.

One of the most interesting aspects of the practice of medicine has been the patient loyalty throughout the years; their love and affection which has lasted. Also the delivering of second generation babies has been quite an interesting experience and has been most gratifying.

During World War II my associate was Captain of the National Guard ambulance group thus at the beginning of the war he was called into service. Two of the other physicians locally enlisted — one in the Navy and one in the Army. Consequently, it left only two of us in 1941 to take care of the entire community and several small surrounding communities. Three or four OB's in a day was not uncommon. We had an Air Force Base at Bruning, Nebraska, so by six o'clock one-half of the Air Force base would be in my waiting room and many times I would go home in the morning to take a shower and then go back to work.

President's Page

PROFESSIONAL STANDARDS REVIEW ORGANIZATION

The matter of PSRO and the position the Nebraska Medical Association has had to assume about it has possibly been one of the more perplexing problems we have had to face during the past year. At this time, very little has been resolved in that regard, and I assume it will again be prominent on the agenda of the AMA's House of Delegates deliberation this June in Chicago.

One item in this regard should be quite clear in the minds of all physicians before any reasonable judgments can be made on its merit. PSRO is frequently confused with Peer Review. We must note that the word, peer, no longer appears in the law or regulations and that the law is not peer review but rather Government regulation and control of the practice of medicine.

The happenings which place us in our present position are these; the AMA in countless hearings and conferences voiced their objections to PSRO and instead suggested a true Peer Review. In spite of all this, the Congress in passing HR-1, a bill which amended the original Social Security Law of 1935, included the amendment which provided for PSRO to be operational by January 1, 1976. This then, by passage of Congress, became Public Law 92-603. This action was taken late in the fall of 1972 just prior to the Clinical Convention of the AMA in Cincinnati in late November of 1972. Even though the law was contrary to the previously stated position of the AMA, the Trustees in Report Z submitted to the Delegates at that meeting, proposed that we support the law and assume a leadership role in the implementation of PSRO.

This policy as outlined by the Trustees and accepted by the Delegates continued to provide considerable debate and at the Annual Session in New York of June, 1973, many resolutions and discussions in opposition were voiced, but after long discussion the policy remained the same.

The objection to PSRO and the AMA's role in relation to it increased over the next several months so at the Clinical Convention of the AMA in Anaheim in December of 1973, there was considerable objection to PSRO. There were sixteen resolutions objecting to PSRO, many demanding repeal. The Trustees report EE advised continuation of the previous policy of cooperation.

The Reference Committee hearings on the matter were the longest on record and when the Reference Committee reports were brought to the House of Delegates, there was again lengthy debate. The question and issue was whether or not the AMA should work for repeal or whether they should continue on the previous course of acceptance and implementation of PSRO. An amendment for repeal was offered by several states (California, Illinois, Michigan, Kentucky, Louisiana and New York). Ambivalence resulted because both the report and amended were adopted.

I observed the proceedings of the Reference Committee and the deliberations of the House of Delegates during both these sessions. It was my judgment and that of any others that the House of Delegates favored repeal of PSRO. From the remarks of Doctor Roth, President, and Doctor Sam-

mons, Chairman of the Board of Trustees, the Officers and the Board of Trustees were not of that mind.

A policy statement has been made by the Trustees of the AMA (January, 1974) which in essence reaffirmed their previous position; to proceed with the implementation of PSRO, feeling that repeal is not politically viable at this time. The Trustees took full advantage of the conflict of their Report EE (status quo) and the amendment which called for repeal.

The Nebraska Medical Association by action of its House of Delegates is on record as favoring repeal of PSRO by endorsing Representative Rarrick's (D., La.) bill. Senator Curtis (R., Nb.) has introduced legislation for repeal of PSRO and the Officers of the NMA have endorsed this. Obviously, this matter is not resolved and while we are making plans to comply with the law, PSRO will continue to be a subject of debate at the Annual Session of the Nebraska Medical Association in May and the Annual Session of the AMA in Chicago this June.

We must decide before January 1, 1976, what course of action we will take if PSRO is not repealed, or found unconstitutional by the courts. There are two basic choices: one, cooperate with HEW in setting up a PSRO. Or, two, allow HEW to establish a PSRO without our cooperation.

All and any member should be fully prepared to discuss the issue at our Annual Session in May, 1974.

John D. Coe, M.D.

The Specialist

ALLERGY

The two words from which we got this one mean other work, and it means an altered to capacity to react. Of course, if you say you are allergic to something, you mean you are sensitive to it, but that's not exactly how it works.

So we go to this fellow when we itch or if we wheeze or sneeze and if we are unable to eat whatever we like to eat. One allergist is supposed to have told a patient that she would be all right after a chicken-soup enema.

You may be sensitive to your cat or dog, to a parakeet, to house dust, to a pillow, or to plants. One may be allergic to one's wife, or just possibly, to a husband. There is pollen, and we have ragweed and goldenrod; we can be sensitive to paint and to powder and lipstick, and to fur. I am sensitive to rabbits, or I was; I don't go near them any more.

And patients can be sensitive to tetanus antitoxin and to penicillin and other antibiotics, and this is important.

These specialists are full of words like allergen, complement, atopy, antigen, hypersensitiveness, and anaphylaxis. Their theories are not easy to understand, but we cannot escape them. For when it is hard for you to breathe, you want to know why, what you must avoid, and how you may overcome your problem.

So you will submit to their patch tests and diets and exlusion procedures, and do whatever these clever people want, so that you may get well. Theirs is a good specialty; their patients don't die, their cures are miraculous, and their patients are grateful. Even Job scratched and scratched, and finally gave up when he got boils.

—F.C.

While Making Rounds

Section On Eponyms.

"Collagen's disease."

"Planter's wart."

On Panels.

The answer usually given by a group of panelists to such burning questions as should doctors smoke and may people be allowed to die is yes but on the other hand no. This leaves you with a firm opinion, not of dying or of smoking, but of panels.

I should like to see a panel discussion of panels.

The Chart.

"Upper extremities: slight weakness of extensors of right foot and toes."

Now You Know.

Parrots and lobsters are left-handed.

Prognosis.

"This defect will be a long time returning, if at all."

Anatomy Lesson.

"Lipoma in left midaxillary line of abdomen."

Learned At A Meeting.

"Parents are lousy teachers."

Dermatology.

"Reveals a 2 ml verruca."

Sort Of An Examination.

"He's studying for his Wassermann test."

Department Of Radiology.

"Impression: Normal study with incomplete filling."

Learned At A Meeting.

Specialist: the fellow who does the rectal you omitted.

NP.

"There was no complaint of headache or sign of headache."

Therapeutics.

"He was given wafers to take along although advised not to take them."

Statistics.

In the U.S., in 1973.

Medical schools	114
In the entering class	13,790
Received M.D. degrees	10,391*
Women graduated	924

*First time over 10,000

The Lab Report.

"Three to four granular cats."

The Consultation.

"A three-hour glucose tolerance test revealed a diabetic type curse."

On Dying.

"The great majority gave no signs one way or the other; like birth, their death was a sleep and a forgetting."

Osler

Reading Maketh A Full Man.

I have finished 50 percent of Ulysses.

Words We Can Do Without.

Genre, unloosen, could care less, attitudinizes, decriminalization, empty calories, workshop.

The Steno.

"Left oracle thickened."

NP.

"He is coherent and cooperative and is almost completely disoriented in time and place."

—F.C.

Down Memory Lane

1. We are living in the "laboratory age." Any method that smacks of laboratory precision has the right of way. Old and tried methods are neglected for laboratory "diagnoses" and reports. Clinical laboratories with their "consultants," like toad-stools, have sprung up overnight. Roentgenologists who will provide diagnoses while you wait are found at every turn.

2. Prior to the modern development of the x-ray and the cystoscope, the diagnosis of urinary stones was a very difficult undertaking.

3. Death by starvation without water is agonizing, with water it is painless.

4. The physician who has taken no particular interest, heretofore, in botanical matters, will be surprised at the ease with which pollen grains can be studied under the microscope and the variety and beauty of form which will be disclosed.

5. After landing in Cuba all troops were ordered revaccinated, again using the ivory points.

6. Graham and Cole have been able to demonstrate the gall bladder by the x-ray.

7. A most uncanny exhibition of the remarkable forward strides of the radio was given. By the use of a special mechanism the entire audience of five hundred or more could distinctly hear the beat of the human heart.

8. A new building is to be built at the

Beatrice Institution for the Feeble-Minded at a cost of $100,000.

9. No age is spared from the various toxic conditions which may justly be charged to the tonsils.

10. A new women's ward, costing approximately $90,000 is being built at the Norfolk State hospital.

Nebraska State Medical Journal
April, 1924

Our Medical Schools

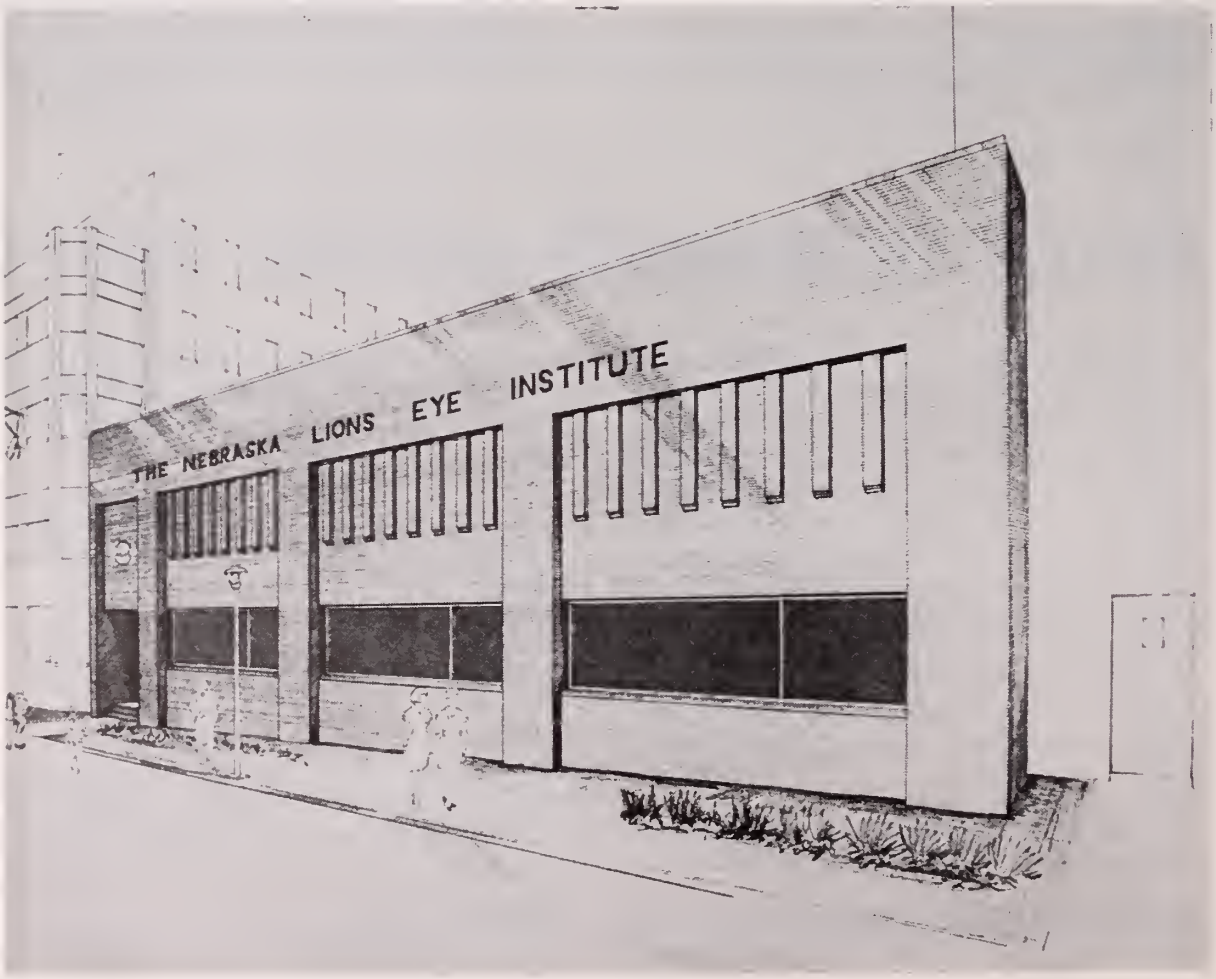
Eye institute at U of N

As we go to press, Senator Carl T. Curtis is to speak at groundbreaking ceremonies for the Nebraska Lions Eye Institute on the University of Nebraska Medical Center campus in Omaha.

The Eye Institute will be built under contracts totaling $411,456. It is expected that it will be completed sometime early in 1975.

Nebraska Lions raised $250,000 over a five-year period to underwrite the Institute.

The University also received $200,000 in Hill-Burton funds and a $25,000 grant from



the Kresge Foundation of Birmingham, Michigan.

The Institute has been designed to aid the medical staff in seeing more clinical patients with eye problems. It will also serve as a teaching center for medical students and be utilized as a clinical research center into the cause, cure and prevention of eye diseases. The Nebraska Lions Eye Bank will also be located in the building.

Creighton clinic moves and renames

Dr. Joseph M. Holthaus, Dean of Creighton University's School of Medicine, has announced that the Creighton Clinic has been renamed and moved from 9th and William to a newer facility at 10th and Dorcas Streets. The new facility is being called the Creighton University Health Center.

Dr. Holthaus said the services provided are essentially the same; some departments have expanded their capabilities and a few have extended their hours of operation. Holthaus said, "The new location, formerly the Saint Joseph Hospital School of Nursing, provides Creighton physicians with more space than they have had in the past. It also facilitates more efficient service and greater comfort for patients." Dr. Holthaus said the Creighton Health Center now makes a complete team of health specialists available to all patients.

Diabetes course

Diabetes mellitus will be the topic of a course at the University of Nebraska Medical Center, May 16 and 17.

Creighton University School of Medicine and the Nebraska Diabetes Association are cosponsors of the course.

Guest faculty includes Dr. James M. B. Bloodworth, Jr., professor and chairman, department of pathology, University of Wisconsin; Dr. Robert F. Bradley, medical director, Joslin Clinic and clinical professor, Harvard University; Judy Jordan, nurse specialist in diabetes, Gainesville, Florida; and Dr. Charles R. Shuman, professor of medicine, Temple University School of Medicine.

Fees include luncheons: They are $60 for physicians; $30 for pharmacists; $30 for nurses; $30 for dietitians; and $30 for other health professionals.

This course is acceptable for 14 prescribed hours by the American Academy of Family Practice and 1.4 continuing education units.

A course on Monday and Tuesday, May 20 and 21, will focus on mental retardation.

Guest speakers include Garry D. Cartwright, director, Nebraska Division of Rehabilitation Services; David Bloom, director, Nebraska Office of Mental Retardation, Department of Institutions; Gerry Griepentrog, programs director, Beatrice State Home, Nebraska Department of Public Institutions; Brian Lensink, director, Douglas County Office of Human Services; and Dr. Charles Galloway, Eastern Nebraska Community Office of Retardation.

Registration fee of $35 includes two luncheons.

The course has been approved for 14 hours of credit by the A.F.F.P. and for 1.4 continuing education units.

Osteoporosis grant at Creighton

A research project started at Creighton University in 1967 has received a $450,000 grant that will insure further study over a five-year period. The money, received from the National Institutes of Health, will partially finance continued study of osteoporosis.

Six years ago Robert P. Heaney, M.D., started a 20-year study of osteoporosis. He planned to record bone size and density and measure calcium metabolism on a large group of women from before menopause until after menopause. In 1969 Dr. Heaney was joined by Paul Saville, M.D. The two had fundamental questions that needed answers. Creighton University established a Metabolic Research Unit at Creighton Memorial Saint Joseph Hospital consisting of

a five-bed laboratory, offices, a food preparation area and examination rooms.

The subjects of the study are 170 nuns. When recruited six years ago, all agreed to be hospitalized for nine days at least once every five years. They would also submit to other examinations as needed.

Drs. Heaney and Saville are quick to emphasize this is not a treatment study. It is simply a systematic observation of the individual as she goes through menopause and develops osteoporosis.

Anatomy grant

The University of Nebraska Medical Center Department of Anatomy recently received a two-year grant for $47,815 from the National Fund for Medical Education. This grant will be used to develop three-dimensional self-instructional units for the teaching of gross anatomy. These units will employ stereo pictures of dissected material in combination with cassette tape recorded descriptions, educational objectives and pre and post tests for evaluation purposes.

With medical knowledge expanding so rapidly, more efficient teaching methods, such as auto-instructional packages, are essential if the future clinician is to learn all he must know to give his patients the best possible care.

Creighton appoints

New appointments at Creighton University School of Medicine this academic year include:

Wadi A. Bardawil, M.D., Professor and Chairman of Pathology

Asit K. Lahiri, Ph.D., Instructor in Pathology

Kathleen Ann Laughlin, M.S.W., Assistant Professor of Preventive Medicine and Public Health

Agapito S. Lorenzo, M.D., Associate Clinical Professor of Psychiatry & Neurology

Matilda S. McIntire, M.D., Professor of Pediatrics to full-time status

Norma Mae Nelson, M.S.W., B.M.E., Instructor in Obstetrics and Gynecology

Tae-Yo O, M.D., Assistant Clinical Professor of Psychiatry and Neurology

Arvind C. Mehta, M.B.B.S., Associate Professor of Psychiatry and Neurology

Sr. M. Leonor Barrion, O.S.B., M.D., Instructor in Pediatrics

Shenna D. Bonnyman, D.P.M., returned as Assistant Professor of Psychiatry and Neurology

John J. Heieck, M.D., Assistant Instructor in Surgery

Francis J. Alessi, M.D., Assistant Instructor in Surgery

Robert Wayne, M.D., Assistant Instructor in Surgery

James J. Kolars, M.D., Assistant Instructor in Obstetrics and Gynecology

Thomas W. Moffat, M.D., Assistant Instructor in Obstetrics and Gynecology

Larry M. Cousins, M.D., Assistant Instructor in Obstetrics and Gynecology

Lonnie R. Mercier, M.D., Clinical Instructor in Orthopedic Surgery

Alan H. Fruin, M.D., Clinical Instructor in Surgery

Dennis G. O'Leary, M.D., Clinical Instructor in Surgery

Internships at U of N

The University of Nebraska Medical Center has matched 47 first-year physicians for next July as a result of the National Intern and Resident Matching Program.

Thirty-five of the newly matched interns are now seniors at the University of Nebraska College of Medicine. One hundred eighteen members of the class of 145 received appointments through the matching program. The others did not participate.

"The majority of our students who were matched are going into areas that are considered 'primary medical care programs,'

that is, family practice, internal medicine, pediatrics and obstetrics-gynecology.

"Twenty-three are going into family practice programs, fifteen of them at the Medical Center," Dr. Scott said.

The internships are assigned by the National Intern and Resident Matching Program, Inc., the official cooperative plan of the American Medical Association, the Student American Medical Association, the Association of American Medical Colleges, the American Board of Medical Specialties, the American Hospital Association, the Catholic Hospital Association and the American Protestant Hospital Association.

The group was organized in 1953 to insure an orderly process of intern placement. Its importance increases as the number of internships continues to outstrip the supply of interns. This year 17,403 internships are available to 10,622 students.

Creighton joins allergy centers

Creighton University is one of the newest additions to a national network of Asthma and Allergic Disease Centers according to a recent announcement made by Dorland J. Davis, M.D., Director of the National Institute of Allergy and Infectious Disease.

Joseph M. Holthaus, M.D., Dean of Creighton's School of Medicine said the new Allergic Disease Center at Creighton will be directed by Robert Townley, M.D., Associate Professor of Medicine. Dr. Townley and his research staff will receive $62,952 from the National Institute of Allergy and Infectious Diseases to support research.

Woman's Auxiliary

Mrs. Howard Liljestrand of Honolulu, Hawaii, the President-elect of the Woman's Auxiliary to the American Medical Association, will join us for all functions of the convention this year. Mrs. Liljestrand has been active in national auxiliary work since 1962. She served as first vice-president, di-

rector, constitutional secretary, treasurer, and as chairman of the committees on Bylaws Structure Review, Membership, Workshop, Big Cities Clinic, and International Health Activities. She was a charter member of the Hawaii auxiliary and served as president of her state in 1960-1961.

Betty Hornor Liljestrand was born in Sioux Rapids, Iowa. She has a B.A. in premedical sciences from Grinnell College in Iowa and an M.A. in cytology from Columbia University in New York City. She completed four summers of study and research at the biological laboratories in Woods Hole, Mass., and in Long Island, N.Y. She was an instructor in zoology at Barnard College, Columbia University, for two years, she set up the secretarial department for pathology and roentgenology at Queen's Hospital in Honolulu, and was business manager and administrative assistant at Leeward Hospital and Clinic, Aiea, Hawaii.

Her husband's specialty is industrial medicine, and he has been active in both state and county medical society activities. The Liljestrands share hobbies of functional design and decorating (they designed and supervised construction of their home which was featured in *House Beautiful* as the pace setter of the year and has been duplicated on four continents), photography, skiing, and travel. The last of their hobbies occupies much time. They have travelled to

and across the Antarctic Circle, through Europe, across the Lapp country, and extensively in the Pacific, having sailed by yacht from Hawaii to Tahiti, Moorea and Bora Bora. Their most recent trip to Europe included a visit to Sweden where they were guests at the Nobel Ceremony and Banquet in 1972.

In Memoriam

By medicine life may be prolong'd yet death
Will seize the doctor too.

—Shakespeare

DR. ARTHUR C. ANTONY

Doctor Arthur C. Antony died on February 3, 1974 at the age of 71. Doctor Antony was born in Chadron, Nebraska on February 15, 1902.

He graduated from the Creighton University School of Medicine in 1924.

Doctor Antony practiced first in Clyde, Kansas and began his practice in Omaha in 1950 where he worked until his retirement approximately two years ago.

Survivors include his wife, Josephine; sons, Arthur C. Jr., and Gary J., both of Omaha; sisters, Mrs. Marie Blundell, Fairbanks, Alaska; Mrs. Anna Bous, Cincinnati, Ohio; Mrs. Adeline Elmer, Buena Vista, Arkansas; Mrs. Bessie Zipfel, San Francisco, California; and nine grandchildren.

DR. VIRGIL S. McDANIEL

Doctor Virgil S. McDaniel died January 2, 1974 at the age of 76. Doctor McDaniel was born in Murray, Nebraska on November 7, 1897.

He was graduated from the University of Nebraska College of Medicine in 1925. He served with the U.S. Public Health Service from 1926 until 1931. From 1934 to 1937 he practiced in Lincoln and in 1937 he moved to Sargent where he remained until 1960. Doctor McDaniel then became a staff member at the Nebraska State Hospital at Ingleside until his retirement in 1965 when he moved to Poulsbo, Washington.

Survivors include his wife, Ellen, of Poulsbo, Washington; two sons, William F. McDaniel, Seattle, Washington and John A. McDaniel, Sargent, Nebraska; two daughters, Dorcelee Coslor, Mount Vernon, Washington and Virginia Horacek, Lawton, Oklahoma; one sister, Mrs. Verna Edwards, Lincoln, Nebraska; one brother, William E. McDaniel, Palm Desert, California; one aunt, Mrs. Minnie I. Wood, Lincoln, Nebraska; and 16 grandchildren.

Welcome New Members

Costas Assimacopoulos, M.D.
St. Joseph's Hospital
Omaha, Nebraska

James A. Bard, M.D.
5440 South Street
Lincoln, Nebraska 68506

Gladys M. Beddoe, M.D.
Department ENT
University of Nebr. Medical Center
Omaha, Nebraska 68105

Joseph Byers, M.D.
David City, Nebraska 68632

Elizabeth D. Edwards, M.D.
902 West "I" Street
McCook, Nebraska 69001

Robert J. Ellingson, M.D.
Nebraska Psychiatric Institute
Omaha, Nebraska 68106

John M. Ford, M.D.
Lexington, Nebraska 68850

Malcolm F. Foster, M.D.
University of Nebr. Medical Center
Omaha, Nebraska 68105

Leon Handke, M.D.
Pierce, Nebraska 68767

Earl M. Howells, M.D.
Creighton Uni. School of Medicine
10th and Castelar
Omaha, Nebraska 68108

Rodney K. Koerber, M.D.
Nebraska City, Nebraska 68410

Marjorie M. C. Kwan, M.D.
1141 Eldon Drive
Lincoln, Nebraska 68510

Gerald J. Langdon, M.D.
119 North 51st Street
Omaha, Nebraska 68132

Roland L. Langley, M.D.
3105 South 46th Avenue
Omaha, Nebraska 68106

Joseph D. Lynch, M.D.
2305 South 10th Street
Omaha, Nebraska 68108

David C. McMaster, M.D.
Auburn, Nebraska 68305

Myrna C. Newland, M.D.
University of Nebr. Medical Center
Omaha, Nebraska 68105

Gary L. Rademacher, M.D.
Nebraska City, Nebraska 68410

Carol L. Scott, M.D.
302 Doctors Building
Omaha, Nebraska 68131

David Sell, M.D.
213 West 38th Street
Scottsbluff, Nebraska 69361

Michael F. Sorrell, M.D.
University of Nebr. Medical Center
Omaha, Nebraska 68105

Manuel G. Suguitan, M.D.
Department of Psychiatry
Douglas County Hospital
Omaha, Nebraska 68105

Stuart P. Westburg, M.D.
140 South 27th Street
Lincoln, Nebraska 68510

John C. Wilcox, M.D.
Aurora, Nebraska 68818

Allen E. Zencka, M.D.
St. Joseph's Hospital
2305 South 10th Street
Omaha, Nebraska 68108

WashingtoNotes

Economic controls

The AMA has announced the filing of a lawsuit against the Cost of Living Council to seek an end to all economic controls on medicine; it is seeking an injunction against the Phase IV regulations on physicians and hospitals. It charged that the rules are "confiscatory, arbitrary and capricious," that they violate the "generally fair and equitable" standard established by Congress, and that they violate the Fifth Amendment of the U.S. Constitution.

In its complaint stating its legal action, the AMA pointed out that the Phase IV regulations represent an "attempt to mold the health care delivery system to comport with the CLC's concepts for health care," and are specifically designed "to curb the quantity and quality of health care services as an integral part of the legislative program to induce Congress to enact national health insurance."

The AMA asked that the court declare these Phase IV regulations invalid and enjoin the Cost of Living Council from enforcing them.

In his statement, Dr. Roth, President of the AMA, said the AMA was filing in U.S. District Court, District of Columbia, a suit seeking an injunction against the Cost of Living Council. "We are asking the court to declare invalid the Phase Four regulations as applied to physicians and hospitals on the grounds that they are confiscatory, arbitrary, capricious and discriminatory.

"But while we proceed on legal grounds, I think it is important to point out that we believe the issues involved are far broader than mere legalisms and that they cast their shadows far beyond the limited scope of Phase IV.

"They are issues of principle and they have profound implications for the future of health care in this country.

". . . It is patently unfair and unreasonable for the services of some working people — namely physicians — to be subject to severe price controls while permitting other working people to function in a free market. That is not fair play; it is an act of discrimination.

"It is patently unfair to apply a revenue margin limitation to physicians in private practice so that they are penalized if they work longer hours and see more patients.

"It is patently unfair when physicians are subject to controls but chiropractors and naturopaths are not . . . when ophthalmologists are subject to controls but optometrists and opticians are not . . . when psychiatrists are subject to controls but clinical psychologists and psychiatric social workers are not. That is not fair play; rather it is an act so arbitrary as to be vindictive.

"Any one of these would be good and sufficient reason to end the controls, in and of itself. For a law that is applied arbitrarily, capriciously, and vindictively is a bad law and ought to be abolished.

"But there are even more compelling reasons why the controls should be abolished — not just from health care but from the entire economy.

"Perhaps the best reason for getting rid of them is that they just don't work."

Cost controls

One day after the AMA filed its suit against the Cost of Living Council President Nixon reaffirmed the Administration's intention to keep cost controls on hospitals and physicians until a national health insurance program is approved.

In a second message on health submitted to Congress, the President also emphasized a shift in policy on health education from operating subsidies to direct assistance to students. Nixon said "The nation's total supply of health professionals is becoming sufficient to meet our needs during the next decade. In fact, oversupply in

the aggregate could possibly become a problem."

On controlling health costs, the President said "We must avoid the cost inflation which followed the introduction of Medicare and Medicaid. Our health insurance proposal would call for states to oversee the operation of insurance carriers and establish sound procedure for cost control. Until these or other controls are in place, I recommend that our present authorities to control health care costs be continued. I am asking the Congress for such authority." Inflationary pressures are still strong in the medical field, he said, "so that we must maintain federal controls until other measures are adopted under comprehensive health insurance.

Preadmission certification

Shortly after an AMA delegation met separately with President Nixon and Health, Education, and Welfare Department Secretary Casper Weinberger, the latter announced he would drop the hotly contested proposed regulations that would have required preadmission certification for the hospitalization of Medicare and Medicaid patients.

The President had assured the AMA delegation that serious consideration would be given to changing the controversial preadmission certification plan.

Other topics discussed by the President and the AMA group included the Administration's plan for statewide fee schedules in its national health insurance proposal and area designations for Professional Standards Review Organizations (PSROs).

The AMA delegation told the President of its opposition to the preadmission certification plan as an unwarranted interference with medical and hospital judgments; contended that continuation of fee controls on physicians would be unfair and punitive; declared that fee schedules in a NHI program would be government regimentation; and suggested that the PSRO program needed regrouping and a new start after encountering stiff resistance from physician groups and much controversy and confusion.

The Chief Executive, according to participants, warmly received the delegation and declared he was aware of the problems physicians face in the area of expanded federal supervision. President Nixon indicated serious consideration would be given to changing the requirements of area or statewide fee schedules in his NHI plan. He stressed that he wished to avoid saddling physicians with unnecessary paperwork that would take time away from patient care.

Health budget

The federal government will spend more than $26 billion next fiscal year on civilian health programs if the Administration's proposed budget is approved by Congress.

The budget reflects the Administration's desire to hold health spending in the fiscal year that begins July 1 to about the level Congress approved for the current fiscal year, considerably more than requested. The exception is an unavoidable $3 billion hike in Medicare and Medicaid outlays.

The new health budget is almost $8 billion over the spending in the fiscal year in 1973 that ended last June.

The budget emphasized two controversial HEW programs of special interest to the medical profession. To carry out the Health Maintenance Organization (HMO) program, $65 million was recommended for the remainder of this fiscal year, and $65 million for next year. The Professional Standards Review Organization (PSRO) program was put down for $34 million through the remainder of the current fiscal year; $58 million, next year.

Coming Meetings

CRIPPLED CHILDREN'S CLINICS—
April 6 — Broken Bow, Elks Lodge
April 27 — Norfolk, Elks Lodge
May 11 — North Platte, Elks Lodge
May 25 — Ainsworth, Elm Grade School

RURAL MEDICAL DAY — April 17, 1974, University of Nebraska College of Medicine, Omaha and Creighton University School of Medicine, Omaha.

M-I-N-K — The Tri-annual joint meeting of the Missouri, Iowa, Nebraska and Kansas Dietetic Associations will be held in Omaha, Nebraska at the Holiday Inn, 72nd and Grover Streets (I-80 and 72nd Streets); April 18th and 19th, 1974; write to: Department of Continuing Education, University of Nebraska Medical Center, 42nd and Dewey Streets, Omaha, Nebraska 68105. Together We Step Into Tomorrow.

NEBRASKA MEDICAL ASSOCIATION — Annual Session, April 28 - May 1, 1974, Hilton Hotel, Omaha, Nebraska.

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS — 22nd Annual Clinical Meeting, April 29 through May 2, 1974, Las Vegas, Nevada. Registration fee for non-members: $125.00. Contact: Mr. Donald F. Richardson, Associate Director, The American College of Obstetricians and Gynecologists, One East Wacker Drive, Chicago, Illinois 60601.

SEMINAR ON ADVANCES IN PEDIATRICS — 14th Annual, at Childrens Memorial Hospital, Omaha, June 6, 7, and 8, 1974. The Seminar is jointly sponsored by the Hospital, Creighton University School of Medicine, and the University of Nebraska School of Medicine. Speakers will include: Dr. H. William Clatworthy, Ohio State University, Pediatric Surgery; Dr. George H. McCracken, Jr., University of Texas, Infectious Disease; Dr. Omar Burgert, Mayo Medical School, Hematology - Oncology; Dr. Joseph E. Ghory, Convalescent Childrens Hospital, Cincinnati, Ohio, Allergy; and faculty members of both local Medical Schools. The registration fee is $50 and includes continental breakfast and lunch. Write: Seminar Committee, Childrens Memorial Hospital, 44th and Dewey, Omaha, Nebraska 68105 for further information.

AMERICAN MEDICAL ASSOCIATION — Annual Session, June 22-27, 1974, Palmer House, Palmer House Towers, Chicago, Illinois.

NEBRASKA MEDICAL ASSOCIATION — Fall Session, October 3-5, 1974, Lincoln, Nebraska.

OMAHA MID - WEST CLINICAL SOCIETY — 42nd Annual Postgraduate Assembly, November 11, 12, and 13, 1974, Omaha Hilton Hotel. Write to: (Mrs.) Mary E. Pilloud, Executive Secretary, 1040 Medical Arts Building, Omaha, Nebraska 68102.

AMERICAN ASSOCIATION FOR CLINICAL IMMUNOLOGY AND ALLERGY — Annual Meeting; Pier 66, Ft. Lauderdale, Florida, November 21-24, 1974. Write to: John L. Dewey, M.D., P. O. Box 912, DTS, Omaha, Nebraska 68101.

AMERICAN MEDICAL ASSOCIATION — 28th Clinical Convention, December 1-4, 1974, Portland, Oregon.

NCME PROGRAMS

March 25 - April 7

ALOPECIA IN DIAGNOSIS.

THE MEDICAL MANAGEMENT OF METASTATIC BREAST CANCER.

THE DIFFERENTIAL DIAGNOSIS OF SYSTEMIC LUPUS ERYTHEMATOSUS.

April 8 - April 21

LONG - TERM MANAGEMENT OF LUPUS ERYTHEMATOSUS.

THE IRRITATED EYE, with Jerome N. Goldman, M.D.

LONG - TERM MANAGEMENT OF SYSTEMIC LUPUS ERYTHEMATOSUS.

THE TREATMENT OF BRONCHIAL ASTHMA.

April 22 - May 5

DIGITALIS: FRIEND OR FOE?

HERPES SIMPLEX: CLUES FOR CLINICAL DIAGNOSIS.

THE TREATMENT OF ACNE.

Medicinews

Nixon on NHI

On February 6, President Nixon delivered to the Congress his message on the Administration's proposed National Health Insurance Program. As he outlined the program, it would have three parts: An Employee Comprehensive Health Insurance Plan would be established for the employed; an "Assisted Health Plan" would be developed for the unemployed and low income groups; and Medicare would be amended and expanded to conform in benefits with the other two programs . . . Proposed benefits include: Hospital care; inpatient and outpatient physician care; drugs; laboratory tests and x-rays; medical devices; ambulance services; and ancillary health care. Coverage would be for all illnesses and conditions, including mental illness, alcoholism, and drug addiction. In addition to other benefits, children would be eligible to receive preventive care to age six, eye and hearing examinations, and regular dental care to age 13. Catastrophic coverage would carry with it a maximum annual deductible of $1,500 per family. The President stated that enrollment in these programs would be voluntary. Program enrollees would be identified by a credit card type of Healthcard, with providers being compensated by an insurance carrier which would, in turn, collect from the patient any deductible or co-payments . . . The Employee Plan specifies that the employer would pay 65% of the premium during the first three years and 75% thereafter. The covered employee, in addition to his portion of the premium, would be responsible for the first $150 each year in medical costs and $50 in drug costs. After the deductibles have been met, the employee would pay 25% of the bills up to an annual maximum of $1500 at which point the catastrophic coverage would take over. The Administration estimates that the annual premium cost to the employee would be $150, and to the employer, $450 . . . The Assisted Medical Plan, which would replace Medicaid, carries an estimated federal cost of $6.9 billion with an additional $1 billion to be paid by the states . . . The present Medicare program would be modified to include the benefits in the other two plans. Medicare beneficiaries would pay the first $100 of medical costs and $50 of

drug costs each year with an annual $750 ceiling on out-of-pocket expenses . . . Citing the climbing costs of health care, the President proposed four cost control measures. First, a requirement that coverage by an HMO be offered to enrollees whenever and wherever such facilities become operational. Second, services rendered under the program would be reviewed by PSROs. Third, a state review of health facility construction to prevent overbuilding of hospitals and other care facilities. Finally, fourth, states would review insurance companies for the purpose of approving specific plans, overseeing rates, ensuring adequate disclosures and take such other steps as are appropriate. For health care providers, the states would "assure fair reimbursement for physician services, drugs, and institutional providers, including a prospective reimbursement system for hospitals" . . . The President concluded his remarks by stating, "Let us continue to have doctors who work for their patients, not for the federal government. Let us build upon the strengths of the medical system we have now, not destroy it" . . Later on Wednesday, House Ways and Means Chairman, Mills (D., Ark.), joined by ranking Republican member Schneebeli (R., Pa.), introduced H.R. 12684, and Finance Committee member Packwood (R., Ore.), introduced S. 2970, identical bills containing the President's proposed NHI program.

AMA urges removal of price controls on doctors

James H. Sammons, M.D., Chairman, AMA Board of Trustees, appeared before the Senate Subcommittee on Production and Stabilization of the Senate Banking, Housing and Urban Affairs Committee to urge that health providers be removed from coverage under the Phase IV economic controls. Citing the physician's record in keeping professional fee increases well below the rate of increases for other services, and the general economy, he stated, "there is no justification for continued economic controls on the medical profession when the Economic Stabilization Act expires on April 30, 1974. Dr. Sammons concluded his detailed remarks, stating, ". . . the Economic Stabilization Program has been administered in a discriminatory and inequitable manner, particularly as it has been and is currently being applied to physicians and other segments of the health sector. Moreover, its general lack of effectiveness is widely recognized. Accordingly . . . the Economic Stabilization Act should not be extended."

More comments to Washington

Again the AMA was particularly active in the submission of comments in Washington . . . *Cancer Act* . . . The AMA submitted a letter to the Kennedy Subcommittee on Health on S. 2893, and to Rep. Rogers' Subcommittee on Public Health and Environment on H.R. 12314, identical bills which would extend the National Cancer Institute authority for an additional three years. While in general support of the legislation, AMA cautioned, "We must question whether the large amount of money being appropriated for cancer research can be effectively used or whether some of that money can be better used in other facets of medical research. We would urge that funding for cancer research be viewed in light of the total medical research activity currently under way in this country. Increased funding for cancer must not compromise other research programs to the detriment of the nation's total health effort." *PSRO Area Designations* . . . The AMA also filed its objections to the proposed PSRO Area Designations which had been published in the Federal Register last December. Stating that there is no basis in law for limiting the number of physicians to be included in a PSRO area, the AMA urged that such limitations be removed and that any state should have the option to form a statewide PSRO. The AMA comments reflected the need for a revision of the designations in final regulations if the law is to be successfully implemented.

Spinal cord injury

The Veterans Administration's seventh postgraduate course in the care of spinal

cord injury patients will be held in Richmond, Va., April 29 through May 3.

The course is primarily designed for continued education of spinal cord traumatologists within the VA spinal cord injury program and also for those in other specialties relevant to the treatment of spinal cord injury patients.

The course is available also to selected physicians of the Armed Forces and physicians from universities and other community hospitals with interest in the care of spinal cord injury patients.

Applications should be submitted to Dr. Peter C. Hofstra, Director, Spinal Cord Injury Service (112J), VA Central Office, 810 Vermont Avenue N.W., Washington, D.C. 20420.

No tuition or registration fee is required. Creditable hours will be available through this course.

Perinatal care

The theme for the annual meeting of the Great Plains Perinatal Care Society is "In the Beginning" (Perinatal Care).

The meeting this year will be at the Thunderbird Motel in Minneapolis, Minnesota, May 19-21.

The speakers and their topics will include:

Dr. Michael Newton, Chicago, Illinois, "Breast Feeding."

Dr. Jack Schneider, University of Wisconsin, Madison, "High Risk Identification Systems."

Dr. Erick Hakanson, St. Paul, Minnesota, "Statewide Approach to Perinatal Mortality and Morbidity."

There will be 16 workshops on different subjects.

The Great Plains Region of the Society includes Iowa, Minnesota, Nebraska, North Dakota, South Dakota, and Wisconsin.

The Letter Box

Dr. Cole:

Being a new subscriber to the Nebraska Medical Journal, I have only been aware of your brand of creativity for just a while. But after reading a few back issues, it dawned on me that "creativity" is not merely a gift, but also a commitment to oneself. Thank you and please keep inspiring.

Respectfully,
Pat Iantorno
College of Pharmacy
Tucson, Arizona

P.S.: Happy Birthday Pouf (sigh).

Dear Dr. Cole:

In the December 1971 issue of the Nebraska State Medical Journal you wrote a delightful essay titled, "Why Do We Write?" I would like your permission to reprint that essay in the *Norden News*.

It has occurred to me that it might help to stimulate a little more participation from some of the clinicians as well as express appreciation for those who do share with their colleagues by contributing articles for publication.

I'm sure that I don't need to explain to you how much arm twisting it sometimes takes to get practitioners to write for a journal. They so often have very good material at their fingertips, but need a great deal of encouragement before they will write it up for publication. Also, I feel that your essays are much too good not to share whenever the occasion presents itself.

I will look forward to hearing from you soon.

Cordially,
(Mrs.) Pat Pike
Editor, *Norden News*

To the Editor:

We have grant funds to sponsor perinatal conferences. Therefore, please place in the next issue of the Nebraska Medical Journal an announcement that all of the physicians listed on these programs, as well as Dr. Marvin Dietrich of the Obstetrics Department, would be willing to meet with any medical society in the state for an evening meeting. We do have money ourselves and this will cost the medical society nothing.

Sincerely,

Gerry Van Leeuwen, M.D.
Professor and Chairman
Department of Pediatrics

Books

Toilet Training in Less Than a Day, by Nathan H. Azrin and Richard M. Foxx; 160 pages; 14.5 by 217.5 cm (5¾ by 8½ in); $4.95 hardcover; published 1974 by Simon and Schuster, New York.

Dr. Azrin is a Ph.D., Head of the Behavior Research Laboratory at Anna State Hospital, Anna, Illinois, and Professor of Rehabilitation at Southern Illinois University.

Dr. Foxx is also a Ph.D. and is Research Psychologist for the State of Illinois Department of Mental Health.

The authors have written another book, "Toilet Training for the Retarded." This book describes a new method, simple and effective, so that the majority of children over 20 months can move from diapers to training pants in less than one day, according to the authors.

There are step-by-step instructions, pictures, and easy-to-read type. There is a list of 99 questions and answers in the back, tables, an appendix, and a good index. I have no one to try the method on, but the book looks interesting; I like it.

—F.C.

Community Psychology and Social Systems by Stanley A. Murrell, Ph.D.; 287 pages; 14 by 21 cm (5½ by 8¼ in); $9.95 hardbound; published 1973 by Behavioral Publications, New York.

The book was written in "the belief that we must find new ways of thinking about man and that man must learn new ways of behaving toward his fellows," and in "the conviction that community psychology, young and uncoordinated as it now is, can contribute importantly to these new ways."

The author is a member of the Department of Psychology in the University of Louisville. The book is divided into 6 chapters, each broken down into some 5 subdivisions. The various sections deal with theory of personality, social system network transactions, and intersystem relationships. There is an index.

—F.C.

Developments in Human Services, Volume 1, edited by Herbert C. Schulberg, Ph.D.; Frank Baker, Ph.D., and Sheldon R. Roen, Ph.D.; 536 pages; 14 by 21 cm (5½ by 8¼ in); $16.95 hardbound; published 1973 by Behavioral Publications, New York.

There are 10 contributors, one of whom is one of the editors. The text deals with Inadequacies in "the human condition" and problems of social arrangements that have created pressures upon professionals. It is intended to be a tool for workers when the effectiveness of human services endeavors will be tested.

It is divided into 4 parts: Teaching health and human services, Planning and administration of human services, Strategies in innovative human services, and Developments in human services education and manpower. There is an index.

—F.C.

Clinical Research for All, by Cyril Maxwell; 15 by 21 cm (6 by 8¼ in); 165 pages; soft cover $8.00; published 1973 by Cambridge Medical Publications Limited, 435/437 Wellingborough Road, Northampton NN1 4EZ, England.

Cyril Maxwell, M.B., Ch.B., is Medical Director and Director of Studies, Clinical Research Services Limited, London, England. The Foreword is by Professor W. Linford Rees, who is an M.D. among other things, is Professor of Psychiatry at the University of London, and Physician in Charge in the Department of Psychological Medicine, St. Bartholomew's Hospital, London.

The book is intended for anyone in a medical or paramedical field who wants to engage in medical research, and who does not know how to go about it. It is nontechnical, it is for beginners, and it is useful.

It is divided into 17 chapters, and has an index. It tells you how to review the literature, how to measure, how to analyze and interpret data. It even tells you how to write the manuscript, and how to submit it for publication. It tells you how to list references, too.

—F.C.

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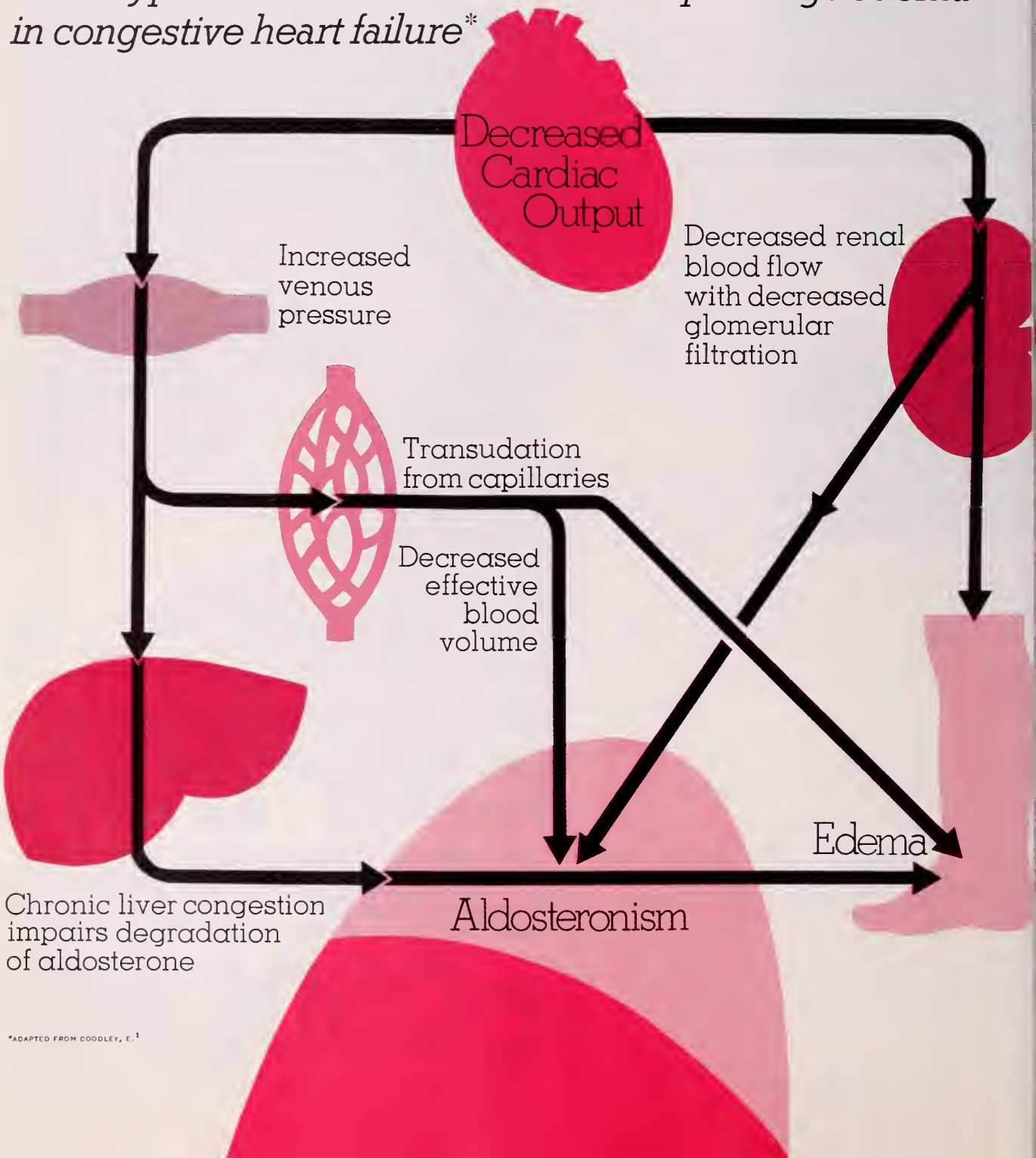

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Aldactone plus "A.D.D." schedule ninimizes potassium deficiency and otentiates effect of "add-on" diuretic.[2]
Avoids acute volume depletion and ldosterone rebound.[2]

. As a daily diuretic in combination with daily dose of a thiazide
Permits daily additive diuretic effect vhile maintaining potassium balance.

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannital or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannital is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: 1. Coodley, E.: Consultant 12:106-107, 109, 111, 113, 115 (July) 1972. **2.** Thorn, G. W., and Lauler, D. P.: Am. J. Med. 53:673-684 (Nov.) 1972.

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These educational materials provide the public with sound, authoritative information about illness, personal health problems and ways to take better care of their health.

Physicians often ask what the AMA really does. This is just one of its many activities -- all made possible by the physicians who support the AMA through their membership. Find out more about the AMA, how it serves the public, how it serves the profession. Just send us the completed coupon.

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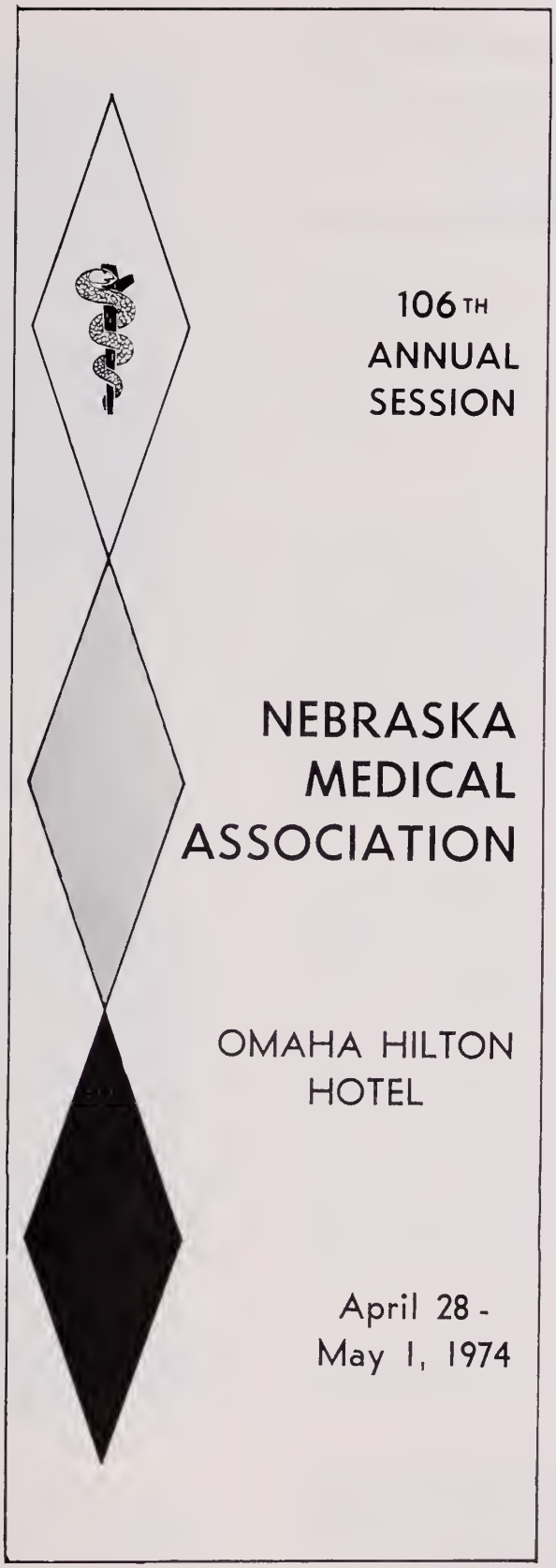
106TH
ANNUAL
SESSION
NEBRASKA
MEDICAL
ASSOCIATION
OMAHA HILTON
HOTEL
April 28 -
May 1, 1974

THINGS YOU SHOULD KNOW

This program is acceptable for 10¼ elective hours by the American Academy of Family Physicians.

REGISTRATION — Grand Ballroom, Omaha Hilton Hotel, 8:00 a.m., Tuesday and Wednesday, April 30 and May 1, 1974.

GENERAL SESSIONS — Grand Ballroom, Omaha Hilton Hotel.

OF SPECIAL INTEREST

PRAYER BREAKFAST — Monday, April 29th, 7:00 a.m., Missouri Room, Omaha Hilton Hotel. "Religious Myths That Hinder The Doctor," The Reverend Gerald E. Hazelrigg, Dundee Presbyterian Church. The Medicine and Religion Committee will sponsor the Prayer Breakfast.

SPORTS MEDICINE LUNCHEON — Tuesday, April 30th, 12:00 noon, Grand Ballroom East, Omaha Hilton Hotel. Speaker — James D. Telfer, M.D., Publisher, Rx SPORTS AND TRAVEL.

PRESIDENT'S RECEPTION — Honoring the President of the Nebraska Medical Association and the President of the Woman's Auxiliary. Tuesday, April 30th, 6:00 p.m., The Firehouse Dinner Theatre's Wine Cellar at 11th and Jackson Streets in the Old Market.

FUN NIGHT — A superb dinner followed by the Firehouse Brigade Singers and a delightful comedy play entitled MY THREE ANGELS at Omaha's unique Firehouse Dinner Theatre in the Old Market. Tickets $12.50 per person. The President's Reception will immediately precede the dinner. Tuesday, April 30th, Firehouse Dinner Theatre, 11th and Jackson Streets in the Old Market. Fun Night is sponsored by the Omaha Medical Society, John C. Filkins, M.D., Chairman.

PAST PRESIDENT'S BREAKFAST — Wednesday, May 1st, 7:00 a.m., Bel-Air Room, Omaha Hilton Hotel.

ANNUAL DISTINGUISHED LUNCHEON — Presidential Address. Installation of New Officers. Recognition of Fifty-Year Practitioners. Syndicated columnist, Mr. Victor Riesel will speak. Wednesday, May 1st, 12:00 noon, Grand Ballroom East, Omaha Hilton Hotel.

SPORTSMAN'S DAY ACTIVITIES

GOLF TOURNAMENT — Highland Country Club, 128th and Pacific, Omaha, Monday, April 29th. Shotgun tee off 1:30 p.m. Participation by preregistration only. John C. Goldner, M.D. and Edward M. Malashock, M.D., Co-Chairmen.

TENNIS — Highland Country Club, 128th and Pacific, Omaha, Monday, April 29th, 1:30 p.m. Participation by preregistration only. Harris B. Graves, M.D., Chairman.

TRAP SHOOT — Location to be announced. Monday, April 29th, 1:30 p.m. Participation by preregistration only. William D. Angle, M.D., Chairman.

SPORTSMAN'S ANNUAL DINNER — Highland Country Club, 128th and Pacific, Omaha, Monday, April 29th. Social Hour at 5:30 p.m. and Sportsman's Annual Dinner at 6:30 p.m.

ANCILLARY MEETINGS

AMERICAN COLLEGE OF SURGEONS, NEBRASKA CHAPTER, ANNUAL BUSINESS MEETING — Sunday, April 28th, 5:30 p.m., Missouri-Iowa Room, Omaha Hilton Hotel.

UNIVERSITY OF NEBRASKA PRECEPTOR BREAKFAST — Tuesday, April 30th, 7:30 a.m., Bel-Air Room, Omaha Hilton Hotel.

UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE ALUMNI MEETING AND SOCIAL HOUR — Tuesday, April 30th, 4:15 p.m., Lewis Room, Omaha Hilton Hotel.

Officers

JOHN D. COE, M.D.
President 1973-1974

JAMES H. DUNLAP, M.D.
President 1974-1975

President

John D. Coe, M.D., Omaha _____1973-1974
James H. Dunlap, M.D., Norfolk _____1974-1975

Secretary-Treasurer

Russell L. Gorthey, M.D. _____Lincoln

Editor

Frank Cole, M.D. _____Lincoln

Executive Secretary

Kenneth E. Neff _____Lincoln

Board of Councilors

District		Term Expires
1.	Thomas J. Gurnett, M.D., Omaha	1975
2.	Louis J. Gogela, M.D., Lincoln	1975
3.	H. C. Stewart, M.D., Pawnee City	1975
4.	Robert B. Benthack, M.D., Wayne	1975
5.	Robert M. Sorensen, M.D., Fremont	1976
6.	Houtz G. Steenburg, M.D., Aurora	1976
7.	Lyle H. Nelson, M.D., Crete	1976
8.	A. Dean Gilg, M.D., Bassett	1976
9.	Hiram R. Walker, M.D., Kearney	1974
10.	Fred J. Rutt, M.D., Hastings	1974
11.	Bruce F. Claussen, M.D., North Platte	1974
12.	A. J. Alderman, M.D., Chadron	1974

Chairman, Board of Councilors

Houtz G. Steenburg, M.D., Aurora _____ 1974

Speaker, House of Delegates

Harry W. McFadden, Jr., M.D., Omaha _____ 1974

Vice Speaker, House of Delegates

Charles W. Landgraf, Jr., M.D., Hastings ____ 1974

Delegates to A.M.A.

John R. Schenken, M.D., Omaha _____ 1974
Roger D. Mason, M.D., McCook _____ 1975

Alternate Delegates to A.M.A.

R. F. Sievers, M.D., Blair _____ 1974
C. J. Cornelius, Jr., M.D., Sidney _____ 1975

Board of Directors

George B. Salter, M.D., Norfolk, Chairman __ 1974
Carl L. Frank, M.D., Scottsbluff _____ 1975
Charles F. Ashby, M.D., Geneva _____ 1976
Dwight W. Burney, Jr., M.D., Omaha _____ 1977
Russell L. Gorthey, M.D., Lincoln

Announcements

House of Delegates

1st Session: Sunday, April 28, 1974, 1:00 p.m., Grand Ballroom East

2nd Session: Monday, April 29, 1974, 8:30 a.m., Grand Ballroom East

3rd Session: Wednesday, May 1, 1974, 7:30 a.m., Grand Ballroom Center

Board of Councilors

1st Session: Sunday, April 28, 1974, 11:00 a.m., Clark Room

2nd Session: Monday, April 29, 1974, 11:00 a.m., Bel-Air Room

Board of Directors

Tuesday, April 30, 1974, 7:30 a.m., Dodge Room

Nominating Committee

1st Session: Monday, April 29, 1974, 10:30 a.m., Conference Room

2nd Session: Tuesday, April 30, 1974, 11:15 a.m., Bel-Air Room

3rd Session: Tuesday, April 30, 1974, 4:15 p.m., Bel-Air Room

Acknowledgements

The Nebraska Medical Association takes this opportunity to recognize and express its appreciation for the grants received from the following organizations:

Pharmaceuticals Division
Ciba-Geigy Corporation

Eli Lilly & Company

Merck Sharp & Dohme

Mutual of Omaha

Nebraska Medical Foundation, Inc.

A. H. Robins Company

Scientific Sessions Committee

Robert M. Stryker, M.D., Chairman _____Omaha

Richard A. Cottingham, M.D. _____McCook

Randolph M. Ferlic, M.D. _____Omaha

Russell L. Gorthey, M.D. _____Lincoln

Joel T. Johnson, M.D. _____Kearney

Y. Scott Moore, M.D. _____Lincoln

Herbert E. Reese, M.D. _____Lincoln

Student Member
Edward E. Gatz, Ph.D. _____Omaha

Technical Exhibitors

American Cancer Society, Nebraska Division, Inc., Omaha, Nebraska

Blue Cross and Blue Shield of Nebraska, Omaha, Nebraska

Bristol Laboratories, Syracuse, New York

Coca-Cola USA, Chicago, Illinois

Cooper Laboratories, Inc., Wayne, New Jersey

Donley Medical Supply Company, Lincoln, Nebraska

Dorsey Laboratories, Lincoln, Nebraska

Encyclopaedia Britannica, Inc., Chicago, Illinois

Mammel/Olson/Schropp/Horn & Swartzbaugh, Inc., Omaha, Nebraska

National Foundation — March of Dimes, Lincoln, Nebraska

Nebraska Heart Association, Inc., Omaha, Nebraska

Nebraska Society for the Prevention of Blindness, Inc., Lincoln, Nebraska

Paul Revere Life Insurance Company, Omaha, Nebraska

Professional Credit Control Inc., Lincoln, Nebraska

Roche Laboratories, Nutley, New Jersey

St. Paul Fire and Marine Insurance Company, St. Paul, Minnesota

Sandoz Pharmaceuticals, Hanover, New Jersey

Schering Laboratories, Kenilworth, New Jersey

E. R. Squibb & Sons, Inc., Princeton, New Jersey

State of Nebraska, Department of Health, Lincoln, Nebraska

Stuart Pharmaceuticals, Division of ICI America Inc., Wilmington, Delaware

System Sales, Inc., Omaha, Nebraska

United States Air Force Medical Services, USAF Medical Placement Office, Kansas City, Missouri

Upjohn Company, Kalamazoo, Michigan

USV Pharmaceutical Corporation, Tuckahoe, New York

Harold J. Westin and Associates, Inc., St. Paul, Minnesota

Woodmen Accident & Life Co., Lincoln, Nebraska

Scientific Exhibits

BIOLOGICAL MARKERS IN CANCER PRONE FAMILIES

Henry T. Lynch, M.D.; Robert Thomas, Ph.D.; Hoda Guirgis, Ph.D.; Don Giard, Ph.D.; Michael Kaplan, M.S.; Jane Lynch, R.N.; Carol Kraft, R.N.; Arnold Kaplan, Ph.D.

Sponsor: Department of Preventive Medicine and Public Health, Creighton University School of Medicine

LITHIUM AND ITS NEWEST CLASS OF PSYCHOTROPIC MEDICATIONS

Duane O. Sherwin, M.D.; Beverley T. Mead, M.D.

Sponsor: Department of Psychiatry and Neurology, Creighton University School of Medicine

INTRAMYOCARDIAL POST-MORTEM ARTERIOGRAPHS, NORMAL AND ABNORMAL

Felix L. Rodriguez, M.D.

Sponsor: Department of Pathology, Creighton University School of Medicine and Creighton Memorial St. Joseph Hospital

FETAL MONITORING

John W. Goldkrand, M.D.; Marvin L. Dietrich, M.D.

Sponsor: University of Nebraska College of Medicine, Omaha

PITFALLS OF OPEN TIBIAL FRACTURES

John F. Connolly, M.D.

Sponsor: University of Nebraska College of Medicine, Omaha

SEGMENTAL NEPHROLITHOTOMY UNDER HYPOTHERMIA

Francis F. Bartone, M.D.; Sushil S. Lacy, M.D.

Sponsor: University of Nebraska College of Medicine, Omaha

CONDENSED SCHEDULE OF PROGRAM

SUNDAY, APRIL 28th

11:00 Board of Councilors, Clark Room

1:00 House of Delegates, Grand Ballroom East

MONDAY, APRIL 29th

Morning

7:00 Prayer Breakfast, Missouri Room

8:30 House of Delegates, Grand Ballroom East

10:30 Nominating Committee, Conference Room

11:00 Board of Councilors, Bel-Air Room

Afternoon

1:30 Golf Tournament, Highland Country Club 128th and Pacific

1:30 Tennis, Highland Country Club 128th and Pacific

1:30 Trap Shoot

5:30 Sportsman's Social Hour, Highland Country Club 128th and Pacific

6:30 Sportsman's Annual Dinner, Highland Country Club 128th and Pacific

TUESDAY, APRIL 30th

Morning

7:30 Board of Directors, Dodge Room

8:00 Registration, Grand Ballroom

8:00 Exhibits Open, Foyer and Grand Ballroom West

9:15 Opening Ceremonies, Grand Ballroom Center
- Welcome
- Invocation
- Necrology

9:30-11:15 Symposium on Gynecologic Cancer, Grand Ballroom Center

11:15 Nominating Committee, Bel-Air Room

11:15 Visit the Exhibits

12:00 Noon Luncheon, Grand Ballroom East

Afternoon

2:00 Visit the Exhibits

2:30-4:15 Symposium on Antibiotics, Grand Ballroom Center

4:15 Nominating Committee, Bel-Air Room

4:15 Visit the Exhibits

6:00 PRESIDENT'S RECEPTION FOR MEMBERS AND WIVES
The Firehouse Dinner Theatre's Wine Cellar
11th and Jackson Streets in the Old Market

7:00 FUN NIGHT
Firehouse Dinner Theatre
11th and Jackson Streets in the Old Market

WEDNESDAY, MAY 1st

Morning

7:00 Past President's Breakfast, Bel-Air Room

7:30 House of Delegates, Grand Ballroom Center

8:00 Registration, Grand Ballroom

8:30 Visit the Exhibits

9:30-11:15 Symposium on Viral Hepatitis, Grand Ballroom Center

11:15 Visit the Exhibits

12:00 Annual Distinguished Luncheon, Grand Ballroom East
Presidential Address
Installation of New Officers
Recognition of Fifty-Year Practitioners
Mr. Victor Riesel — Syndicated Columnist

Afternoon

2:00-5:00 Symposium on What's New in Medicine,
"Little Problems With Big Consequences"

Grand Ballroom Center

George C. Lewis, Jr., M.D.
Philadelphia, Pennsylvania

Doctor Lewis graduated from the University of Pennsylvania School of Medicine in 1944. He currently serves as Professor of Obstetrics and Gynecology at Jefferson Medical College of Thomas Jefferson University. He is on the active staff of the Thomas Jefferson University Hospital. He has a special interest in the subspecialization of gynecologic oncology and is a member of the Division of Gynecologic Oncology, of the American Board of Obstetrics and Gynecology. Doctor Lewis was one of the founders of the Society of Gynecologic Oncologists and the first President of the organization.

Donn G. Mosser, M.D.
Minneapolis, Minnesota

Doctor Mosser graduated from the University of Kansas School of Medicine in 1946. He currently serves as Clinical Professor of Radiation Therapy at the University of Minnesota Medical School. He is also Director of Radiation Therapy at Northwestern Hospital in Minneapolis. Doctor Mosser is a member of the Board of Trustees of the Minnesota Medical Foundation and a member of the Editorial Board of MODERN MEDICINE. He is also serving on various committees of the Minnesota State Medical Association.

PROGRAM

Nebraska Medical Association

106th Annual Session

TUESDAY, MORNING, APRIL 30, 1974

8:00 Registration, Grand Ballroom

8:00 Exhibits Open, Foyer and Grand Ballroom West

Coffee available in Exhibit Area

9:15 **OPENING CEREMONIES — Grand Ballroom Center**

Welcome

—John D. Coe, M.D., President

Invocation

—Roger D. Mason, M.D., Delegate to the AMA

Necrology

—George B. Salter, M.D., Chairman, NMA Board of Directors

9:30 to 11:15 **SYMPOSIUM ON GYNECOLOGIC CANCER — Grand Ballroom Center**

Moderator—

Daniel G. Bohi, M.D., Omaha
Obstetrics and Gynecology

"Improving Your Results With Endometrial Cancer Patients"

—George C. Lewis, Jr., M.D., Philadelphia, Pennsylvania

Professor, Obstetrics and Gynecology, Jefferson Medical College of Thomas Jefferson University

"The Place of Radiation Therapy in Endometrial Cancer"

—Donn G. Mosser, M.D., Minneapolis, Minnesota

Clinical Professor of Radiation Therapy, University of Minnesota Medical School

Questions and Discussion

11:15 Visit the Exhibits

PROGRAM

TUESDAY NOON, APRIL 30, 1974

12:00 NOON LUNCHEON — Grand Ballroom East

Sponsored by the NMA Sub-Committee on Athletic Injuries

John E. Murphy, M.D., Chairman

—John D. Coe, M.D., President, Presiding

James D. Telfer, M.D.
Hillsboro, Illinois

Doctor Telfer graduated from the University of Louisville School of Medicine in 1958. He is a family practitioner in Hillsboro and also publishes Rx SPORTS AND TRAVEL magazine, the first leisure magazine for physicians. Doctor Telfer's background is varied: a radiation geneticist, first Director of the U.S.A.F. Space Biology Laboratory, and he was in biophysical research at the University of Virginia Medical School. The U.S. Medical Open Golf Tournament was begun by Doctor Telfer, and in 1973 he became the first foreign member of the British Medical Golfing Society. Doctor Telfer was Captain of the 1972 and 1973 U.S. Medical Golf Team.

"At Arm's Length, Returned"

—James D. Telfer, M.D.

Publisher, Rx SPORTS AND TRAVEL
Hillsboro, Illinois

Presentation of AMA-ERF Checks

2:00 Visit the Exhibits

PROGRAM

TUESDAY AFTERNOON, APRIL 30, 1974

2:30 to 4:15 SYMPOSIUM ON ANTIBIOTICS — Grand Ballroom Center

Moderator—

Stuart P. Embury, M.D., Holdrege
Family Practice

"Newer Antibiotics — Fact or Folklore"

—W. Eugene Sanders, Jr., M.D., Omaha
Professor and Chairman
Department of Medical Microbiology
Creighton University School of Medicine

"Current Trends in the Diagnosis and Treatment of Venereal Disease"

—Malcolm T. Foster, Jr., M.D., Omaha
Vice Chairman
Department of Internal Medicine
University of Nebraska Medical Center

Questions and Discussion

4:15 Visit the Exhibits

PROGRAM

TUESDAY EVENING, APRIL 30, 1974

6:00 PRESIDENT'S RECEPTION for Members and Wives

The Firehouse Dinner Theatre's Wine Cellar
11th and Jackson Streets in the Old Market

7:00 FUN NIGHT

The Firehouse Dinner Theatre
11th and Jackson Streets in the Old Market

John C. Filkins, M.D., Chairman

An evening of fun and entertainment at the Firehouse Dinner Theatre located in Omaha's Old Market. A delightful dinner followed by the Firehouse Brigade Singers and a play entitled . . .

My Three Angels

. . . A delightful comedy, with villains doing the work of angels by defending goodness. Based on a French novel, 'My Three Angels,' which had a long Broadway run.

PROGRAM

WEDNESDAY MORNING, MAY 1, 1974

8:00 Registration, Grand Ballroom

8:30 Visit the Exhibits
Coffee available in Exhibit Area

9:30 to 11:15 SYMPOSIUM ON VIRAL HEPATITIS — Grand Ballroom Center

9:30 "New Advances in Viral Hepatitis"

—Moderator — Michael F. Sorrell, M.D., Omaha
Associate Professor
Department of Internal Medicine
University of Nebraska Medical Center

9:40 "Hepatitis Associated Antigen; Its Implications in Viral Hepatitis"

—John B. Byrd, M.D., Kimball
Family Practice

9:55 "Diagnosis, Management and Sequelae of Acute Viral Hepatitis"

—James L. Boyer, M.D., Chicago, Illinois
Director, Liver Study Unit
Department of Medicine
The Pritzker School of Medicine of the University of Chicago

James L. Boyer, M.D.
Chicago, Illinois

Doctor Boyer graduated from John Hopkins University School of Medicine in 1962. He currently serves as Director of the Liver Study Unit at the University of Chicago. His major research interests consist of studies in the pathogenesis of acute and chronic liver injury and physiologic mechanisms of bile secretion and biliary transport. Doctor Boyer is a Fellow of the American College of Physicians, a member of the Central Society, Midwestern GUT Club, American Gastroenterological Association, The American Federation for Clinical Research and the American Association for the Studies of Liver Disease. Doctor Boyer also serves as an Associate Professor of Medicine at the University of Chicago.

10:45 Questions and Discussion

11:15 Visit the Exhibits

PROGRAM

WEDNESDAY NOON, MAY 1, 1974

MR. VICTOR RIESEL, Syndicated Columnist
New York, New York

Prize-winning, nationally syndicated newspaper columnist Victor Riesel has won nineteen journalistic awards; has travelled more than a million miles to win them; has interviewed scores of heads of state, from Richard Nixon and Ed Heath to Harold Wilson, and from Golda Meir to the late Abdul Nasser, to achieve such recognition. Mr. Riesel writes for 357 daily newspapers. He has been President of the Overseas Press Club of America and is Vice President of the Association of Radio and Television News Analysts. He is Chairman of the Freedom of the Press and Performers Rights Committee of the American Federation of Radio and Television Artists. Mr. Riesel has served as an instructor at a London college, been a guest lecturer at a series of American universities, and been an advisor to a Joint Legislative Committee on Crime and Its Causes.

PROGRAM

WEDNESDAY NOON, MAY 1, 1974

12:00 ANNUAL DISTINGUISHED LUNCHEON
—Grand Ballroom East

For Members and Wives

—Maurice M. Steinberg, M.D., President
Omaha Medical Society,
Presiding

Presidential Address
—John D. Coe, M.D.

Installation of James H. Dunlap, M.D.

Recognition of Fifty-Year Practitioners

Clarence F. Bantin, M.D.
Omaha

Walter Benthack, M.D.
Wayne

David M. Bloch, M.D.
Arlington

Bernard C. Burns, Sr., M.D.
Omaha

Harry R. Elston, M.D.
Omaha

Max Fleishman, M.D.
Omaha

Luther V. Gibson, M.D.
Lincoln

George A. Haslam, M.D.
Fremont

Dwight O. Hughes, M.D.
Fairbury

J. Hewitt Judd, M.D.
Omaha

William C. Kenner, Jr., M.D.
Nebraska City

Van H. Magill, M.D.
Curtis

Morris Margolin, M.D.
Omaha

Forrest A. Mountford, M.D.
Davenport

Paul A. Reed, M.D.
Deshler

Speaker
—Mr. Victor Riesel

PROGRAM

WEDNESDAY AFTERNOON, MAY 1, 1974

2:00 to 5:00 **SYMPOSIUM ON WHAT'S NEW IN MEDICINE** — Grand Ballroom Center

"Little Problems With Big Consequences"

General Moderator—
Randolph M. Ferlic, M.D., Omaha
Cardiovascular and Thoracic Surgery

Five Simultaneous Round Table Discussions Scheduled in Thirty-Minute Segments.

An Aura of Informality and Free Discussion Will Prevail.

PROGRAM

WEDNESDAY AFTERNOON, MAY 1, 1974

2:00 to 5:00

"Fracture Clinic"

—Moderator — William R. Hamsa, Jr., M.D., Omaha
Orthopedic Surgery

—Bruce F. Claussen, M.D., North Platte
Orthopedic Surgery

—Bernard L. Kratochvil, M.D., Omaha
Orthopedic Surgery

"Cardiac Arrhythmias"

—Moderator — Walt F. Weaver, M.D., Lincoln
Internal Medicine — Cardiovascular Disease

—Paul K. Mooring, M.D., Omaha
Pediatrics — Pediatric Cardiology

—William M. Vosik, M.D., Kearney
Internal Medicine

"Obstetrical Problems"

—Moderator — Robert J. Luby, M.D., Omaha
Obstetrics and Gynecology

—Dennis D. Beavers, M.D., Omaha
Obstetrics and Gynecology

—James D. Eisen, Ph.D., Omaha
Human Genetics (Pediatrics)

"Hand Injuries"

—Moderator — M. Edward Baccari, M.D., Omaha
Plastic Surgery

—Larry D. Ruth, M.D., Lincoln
Plastic Surgery

—Samuel A. Swenson, Jr., M.D., Omaha
General Surgery

—Thomas H. Wallace, M.D., Gordon
Family Practice - Surgery

"Investments"

—Moderator — Daniel C. Ahern, Omaha
Branch Manager, A. G. Edwards and Sons Inc.

—Arnold Abramson, Coral Gables, Florida
Vice President, I.R.E., Real Estate Partners Ltd.

—Darrell Plocher, Chesterfield, Missouri
Regional Vice President, Colonial Management Associates, Inc.

—David S. Rice, Omaha
Assistant Resident Manager, A. G. Edwards and Sons Inc.

Woman's Auxiliary

MRS. WARREN G. BOSLEY

Grand Island, Nebraska

President, 1973-1974

MRS. KENNETH T. McGINNIS

Lincoln, Nebraska

President, 1974-1975

MRS. HOWARD LILJESTRAND

Honolulu, Hawaii

President-elect Woman's Auxiliary to the American Medical Association

Woman's Auxiliary

NEBRASKA MEDICAL ASSOCIATION
49th ANNUAL MEETING

ALL NEBRASKA PHYSICIANS' WIVES ARE CORDIALLY INVITED TO REGISTER AND ATTEND ANY OR ALL PROGRAMS.

Registration:

Sunday, April 28th — 3:00-5:00 p.m., Ballroom, Omaha Hilton Hotel

Monday, April 29th — 8:30 a.m. to 3:00 p.m., Ballroom, Omaha Hilton Hotel

Tuesday, April 30th — 8:30 a.m. to 12:30 p.m., Ballroom, Omaha Hilton Hotel

Wednesday, May 1st — 8:30 a.m. to 10:00 a.m., Ballroom, Omaha Hilton Hotel

OMAHA MEDICAL SOCIETY AUXILIARY
Hostess Auxiliary

Convention Committee

Mrs. Denham Harman, General Chairman

Mrs. Barney B. Rees, Hospitality

Mrs. John D. Coe, Publicity

Mrs. Leland J. Olson, Hostess, Monday Dinner

Mrs. Donald J. Pavelka, Hostess, Fun Night

Mrs. Robert D. Sparks, University Tour, Luncheon

Mrs. Arnold W. Lempka, Fashion Show

Woman's Auxiliary

PROGRAM

MONDAY, APRIL 29, 1974

Morning

8:30-
3:00 Registration, Ballroom, Omaha Hilton Hotel

9:30 Bus leaves Omaha Hilton Hotel (Main Entrance) for Coffee Hour, Tour: University of Nebraska College of Medicine, 42nd and Dewey Sts.

10:15 Greetings, Dr. Robert D. Sparks, Chancellor, Medical School

Tour: Pediatric Pavilion, Nuclear Medicine Center, Neo-natology, Library

12:00 Luncheon, Executive Dining Room, University Hospital

Afternoon

1:30 Annual Business Meeting

Mrs. Warren G. Bosley, Presiding
(All members invited)

Reports of Officers and State Chairmen

Reports of County Presidents

Memorial Service

Election of Officers

50th Anniversary WA-AMA Presentation from San Francisco Convention

6:00 Cocktail, No-Host Dinner

Omaha Press Club, Atop First National Center adjoining the Omaha Hilton Hotel

Woman's Auxiliary

PROGRAM

TUESDAY, APRIL 30, 1974

Morning

8:30-
12:30 Registration, Ballroom, Omaha Hilton Hotel

Afternoon

12:00- Social Hour and Luncheon
1:00 The French Cafe
1017 Howard Street in the Old Market
(Tickets at Auxiliary Registration Desk)

Fashion Show — NEBRASKA CLOTHING STORE

Guest — Mrs. Howard Liljestrand, Honolulu, Hawaii, President-elect, Woman's Auxiliary to the AMA

Installation of New Officers

5:30 President's Reception for Members and Wives

The Firehouse Dinner Theatre's Wine Cellar
11th and Jackson Streets in the Old Market

Evening

7:00 FUN NIGHT
Firehouse Dinner Theatre
Play — My Three Angels

WEDNESDAY, MAY 1, 1974

Morning

8:30-
10:00 Registration, Ballroom, Omaha Hilton Hotel

8:30 Continental Breakfast, Lewis Room, Omaha Hilton Hotel

9:00 Post-Convention Board Meeting, Lewis Room, Omaha Hilton Hotel

Mrs. Kenneth T. McGinnis, Presiding

Afternoon

12:30 Combined Auxiliary-Association Luncheon
Grand Ballroom, Omaha Hilton Hotel

Presidential Address

Installation of James H. Dunlap, M.D.

Recognition of Fifty-Year Practitioners

Speaker — Mr. Victor Riesel

Past Presidents
Nebraska Medical Association

Gilbert C. Monell, M.D., Omaha _____1868-69
James H. Peabody, M.D., Omaha _____1969-70
N. B. Larsh, M.D., Nebraska City _____1870-71
R. R. Livingston, M.D., Plattsmouth _____1871-72
A. Bowen, M.D., Nebraska City _____1872-73
H. P. Mathewson, M.D., Omaha _____1873-74
John Black, M.D., Plattsmouth _____1874-75
L. H. Robbins, M.D., Lincoln _____1875-76
J. P. Peck, M.D., Omaha _____1876-77
L. J. Abbott, M.D., Fremont _____1877-78
E. M. Whitten, M.D., Nebraska City _____1878-79
Harvey Link, M.D., Millard _____1879-80
S. D. Mercer, M.D., Omaha _____1880-81
M. W. Stone, M.D., South Omaha _____1881-82
A. H. Sowers, M.D., Lincoln _____1882-83
Victor H. Coffman, M.D., Omaha _____1883-84
F. G. Fuller, M.D., Grand Island _____1884-85
W. W. Knapp, M.D., Lincoln _____1885-86
Richard C. Moore, M.D., Omaha _____1886-87
George H. Peebles, M.D., Lincoln _____1887-88
Milton Lane, M.D., Kearney _____1888-89
J. C. Denise, M.D., Omaha _____1889-90
D. A. Walden, M.D., Beatrice _____1890-91
Charles Inches, M.D., Scribner _____1891-92
M. L. Hildreth, M.D., Lyons _____1892-93
A. S. von Mansfelde, M.D., Ashland _____1893-94
H. B. Lowry, M.D., Lincoln _____1894-95
J. E. Summers, M.D., Omaha _____1895-96
F. D. Haldeman, M.D., Ord _____1896-97
Wilson O. Bridges, M.D., Omaha _____1897-98
A. R. Mitchell, M.D., Lincoln _____1898-99
Robert McConaughy, M.D., York _____1899-00
H. M. McClanahan, M.D., Omaha _____1900-01
Wm. B. Eby, M.D., Ainsworth _____1901-02
A. B. Anderson, M.D., Pawnee City _____1902-03
B. F. Crummer, M.D., Omaha _____1903-04
R. C. McDonald, M.D., Fremont _____1904-05
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Technical Exhibitors

106th Annual Session

AMERICAN CANCER SOCIETY, NEBRASKA DIVISION, INC., Omaha, Nebraska — Cancer of the cervix is presented as a continuum from dysplasia through cancer in situ to invasive cancer with a management chart for the disease. Mortality rates and the declining incidence of invasive cancer of the cervix compared to the rising rate of in situ cancer are shown to emphasize the value of early detection. Approaches for improvement in the control of cervical cancer are presented.

BLUE CROSS AND BLUE SHIELD OF NEBRASKA, Omaha, Nebraska — Physicians are encouraged to stop by at our booth. Well-informed Plan representatives will be available to explain Blue Shield and Blue Cross policies and procedures on subjects such as the Usual, Customary, and Reasonable Fee Concept and the Hospital Concurrent Utilization Review Program which is now operating in twenty Nebraska Hospitals. Also, any service type problems that physicians may be having with our Plans can be discussed with these representatives.

BRISTOL LABORATORIES, Syracuse, New York — You are cordially invited to visit our exhibit reflecting Bristol's leadership and enduring commitment to the manufacturer of life-saving antibiotics. For your consideration, the following Bristol products are featured: Versapen® (hetacillin), Kantrex® (kanamycin sulfate), Tetrex® (tetracycline phosphate complex), Prostaphlin® (sodium oxacillin), Salutensin® (hydroflumethiazide and reserpine), Bristamycin® (erythromycin stearate), Naldecon® (antihistamine decongestant), and Polycillin® (ampicillin trihydrate). Our representatives welcome the opportunity to answer your inquiries.

DORSEY LABORATORIES, Lincoln, Nebraska — Dorsey Laboratories will be presenting medical-educational information on smoking control and otitis media. Product information and samples will be available on Klorvess, Metaprel and members of the Triaminic family. We would welcome your visit and would like to make our services available to you.

ENCYCLOPAEDIA BRITANNICA, INC., Chicago, Illinois — Encyclopaedia Britannica welcomes physicians to the 106th Annual Session of the Nebraska Medical Association. As part of our exhibit, we will have on display the great new edition of Britannica III, the Britannica Junior and other related products. Stop and inspect these products in Booth #11. They are available to registrants at our convention offer.

MAMMEL/OLSON/SCHROPP/HORN & SWARTZBAUGH, INC., Omaha, Nebraska — We will be presenting our services in the areas of: Employee (Fringe) Benefit Consulting for Professional Corporations.

NEBRASKA HEART ASSOCIATION, INC., Omaha, Nebraska — The Professional Education Committee of the Nebraska Heart Association will present a display depicting the myriad efforts of the Heart Association in orienting the practicing physician to the detection of previously unknown hypertensive populations.

NEBRASKA SOCIETY FOR THE PREVENTION OF BLINDNESS, INC., Lincoln, Nebraska— The Nebraska Society for the Prevention of Blindness exhibit will emphasize the Home Eye Test for Preschoolers, cataracts, glaucoma and other eye diseases and problems. A wealth of material including: films, pamphlets, Home Eye Test Kits and Home Eye Counter Top Easels will be displayed and made available free upon request.

PAUL REVERE LIFE INSURANCE COMPANY, Omaha, Nebraska — The Paul Revere Insurance Company is nationally recognized as a leader in the noncancellable Health Insurance industry. The sales portfolio of the Companies includes: (1) noncancellable, guaranteed continuable, guaranteed premium disability income, (2) all forms of life insurance, (3) attractive pension plans, especially for small and medium-sized corporations, (4) mutual funds and variable annuities in states where approved. As a pioneer in a dynamic industry, The Paul Revere offers the fullest and finest range of personal financial services.

ST. PAUL FIRE AND MARINE INSURANCE COMPANY, St. Paul, Minnesota — The purpose of our exhibit is to have Company people in attendance to answer any questions concerning coverage, rating or claims pertaining to Doctors' Malpractice Insurance as endorsed for The ST. PAUL INSURANCE COMPANIES by the Nebraska Medical Association.

SANDOZ PHARMACEUTICALS, Hanover, New Jersey — Sandoz Pharmaceuticals cordially invites you to visit our display at Booth #1, where we are featuring MELLARIL, HYDERGINE and SANOREX. Any of our representatives in attendance will gladly answer questions about these and other Sandoz products.

SCHERING LABORATORIES, Kenilworth, New Jersey — SCHERING LABORATORIES' exhibit which is located in Booth #9 is featuring GARAMYCIN® Injectable, ETRAFON® and DRIXORAL®. Our representatives are available to answer any questions you may have.

Technical Exhibitors

106th Annual Session

E. R. SQUIBB & SONS, INC., Princeton, New Jersey — E. R. Squibb & Sons, Inc., has long been a leader in the development of new therapeutic agents and equipment for the prevention and treatment of disease. You are cordially invited to meet our pharmaceutical representatives who will be available at our exhibit to discuss our full line of products.

STATE OF NEBRASKA, DEPARTMENT OF HEALTH, Lincoln, Nebraska — Illustration of Community Health Services in existence within the State with projected sites of counties/communities that have shown an interest in obtaining such through the Department's Demonstration Program in community Health.

STUART PHARMACEUTICALS, DIVISION OF ICI AMERICA INC., Wilmington, Delaware — The Stuart Pharmaceuticals booth consists of graphic panels, product samples and literature describing some or all of the following products: MYLANTA, CHEWABLE SORBITRATE, SORBITRATE Sublingual and Oral, KINESED, STUARTNATAL 1+1, and others.

SYSTEM SALES, INC., Omaha, Nebraska — Control-O-Fax — Complete one-write office systems to increase collections and reduce office paperwork.

UNITED STATES AIR FORCE MEDICAL SERVICES, USAF MEDICAL PLACEMENT OFFICE, Kansas City, Missouri — A lighted exhibit will be used and informational materials showing Medical Education opportunities, including Scholarship Program and aids will be available.

UPJOHN COMPANY, Kalamazoo, Michigan — Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. They are here to discuss products of Upjohn research designed to assist you in the practice of your profession. They welcome your inquiries and comments.

HAROLD J. WESTIN AND ASSOCIATES, INC., St. Paul, Minnesota — HAROLD J. WESTIN & ASSOCIATES, St. Paul, Minnesota, are specialists in the design and construction of medical clinics, they guarantee their preliminary budget — guarantee the quality of the building — give a certified accounting for all expenditures, and provide professional construction management — passing the savings on to the Owner.

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Scientific Exhibits

106th Annual Session

BIOLOGICAL MARKERS IN CANCER PRONE FAMILIES

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LITHIUM AND ITS NEWEST CLASS OF PSYCHOTROPIC MEDICATIONS

Duane O. Sherwin, M.D.; Beverley T. Mead, M.D.

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INTRAMYOCARDIAL POST-MORTEM ARTERIOGRAPHS, NORMAL AND ABNORMAL

Felix L. Rodriguez, M.D.

Sponsor: Department of Pathology, Creighton University School of Medicine and Creighton Memorial St. Joseph Hospital

FETAL MONITORING

John W. Goldkrand, M.D.; Marvin L. Dietrich, M.D.

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PITFALLS OF OPEN TIBIAL FRACTURES

John F. Connolly, M.D.

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SEGMENTAL NEPHROLITHOTOMY UNDER HYPOTHERMIA

Francis F. Bartone, M.D.; Sushil S. Lacy, M.D.

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Rim Sign in Brain Scintigraphy of Epidural Hematoma — K. G. T. Brugge (25 Leonard Ave, Toronto) and H. Meindok. J Nucl Med 14:709-710 (Sept) 1973.

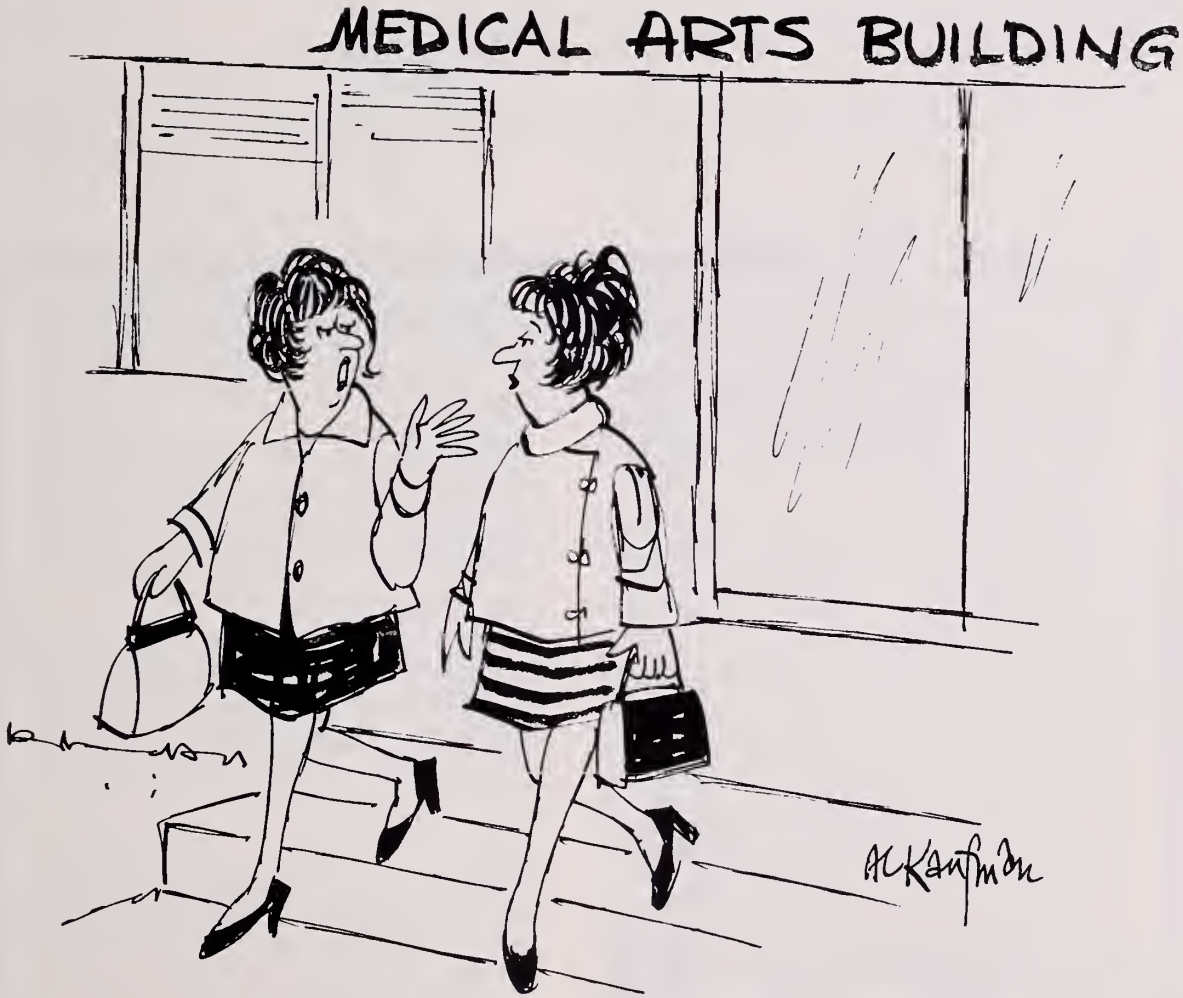
Gamma camera pictures of a so-called rim sign are shown in an epidural hematoma with a photograph taken during craniotomy. A rim sign was previously described in subdural hematomata and deeper cerebral lesions. A rim sign in the brain scan in cases of head injury is good evidence of either subdural or epidural hematoma.

Modern Tuberculosis Control: Six Year Follow-up in Appalachian Community — M. L. Furcolow (Univ of Kentucky College of Medicine, Lexington 40506) and K. W. Deuschle. Am Rev Resp Dis 107:253-266 (Feb) 1973.

Tuberculosis control methods in a small county of 10,000 persons consisted of identification of active and suspect tuberculosis by skin testing and x-raying the entire community, placing patients and suspects under therapy, and prevention of breakdown in those with positive skin tests but normal x-rays by prophylactic treatment with INH. Over a six-year observation period, no cases of active tuberculosis developed in the target group (INH prophylaxis of tuberculin reactors) of 934 persons although six were expected.

Cytotoxic Lymphocytes: Part II — J. G. Sinkovics et al (Univ of Texas M. D. Anderson Hosp, Houston 77025). Tex Rep Biol Med 30:347-360 (No. 4) 1972.

Patients with sarcomas circulate lymphoid cells which exert a prompt cytotoxic effect on cultured allogeneic sarcoma cells; carcinoma cells exposed to lymphocytes of these patients grow uninhibitedly for several days and undergo cytotoxic damage only in the end-phase of the reaction. The serum of a patient who rapidly died with a disseminated rhabdomyosarcoma contained factors which specifically blocked the cytotoxic effect of lymphocytes from two other patients with rhabdomyosarcoma against an established cell line of this tumor. The lymphocytes of two normal donors acquired cytotoxic activity to this cell line in vitro.



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Physicians' Classified

Advertisements in this column are at a rate of ten cents per word with a minimum of $4.00 per insertion. Copy must be received by the fifth of the month preceding date of publication and should not exceed 50 words. Advertisements from members of the Nebraska Medical Association will be accepted without charge for one issue. Each advertisement will be taken out following its first appearance unless otherwise instructed. Where numbers follow advertisements, replies should be addressed in care of The Nebraska Medical Journal, 1902 First National Bank Building, Lincoln, Nebraska 68508.

GENERAL PRACTITIONERS NEEDED — County seat town, North-Central Nebraska. Clinic available across street from modern 34-bed hospital. Three nursing homes nearby, large trade area. Affiliation possible if desired. If interested, call or write Charles Sweet, M.D., 140 South 4th; Roy J. Smith, M.D., 732 West Fairview; or Administrator, Boone County Community Hospital, Albion, Nebraska 68620.

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PHYSICIAN arriving in Nebraska in early April wishes part-time college health, school physician, or institutional care position in late April and May. Lincoln or Omaha location preferable. Contact Box #43, NEBRASKA MEDICAL JOURNAL, 1902 First National Bank Building, Lincoln, Nebraska 68508.

MEDICAL OFFICE FOR RENT OR LEASE — Cot-Nor Incorporated Suite 500 with 1,015 sq. feet located at 5440 South Street, Lincoln, Nebraska. Abundant parking available. If interested, contact Mr. Dick Gaughan, Manager of Cot-Nor Incorporated, Suite 1600, 5440 South Street, Lincoln, Nebraska 68506. Phone: (402) 489-2718.

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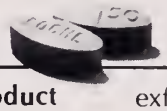

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis*, and, less frequently, indole-positive proteus species).

Note: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in chronic and recurrent urinary tract infections.

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Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia in elderly patients on diuretics, primarily thiazides. Sore throat, fever, pallor or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. Data are insufficient to recommend use in infants and children under 12.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, allergy or bronchial asthma; and in those with glucose-6-phosphate dehydrogenase deficiency, where hemolysis may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12.

Usual adult dosage: Two tablets b.i.d. for 10 to 14 days. For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

Supplied: Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10.

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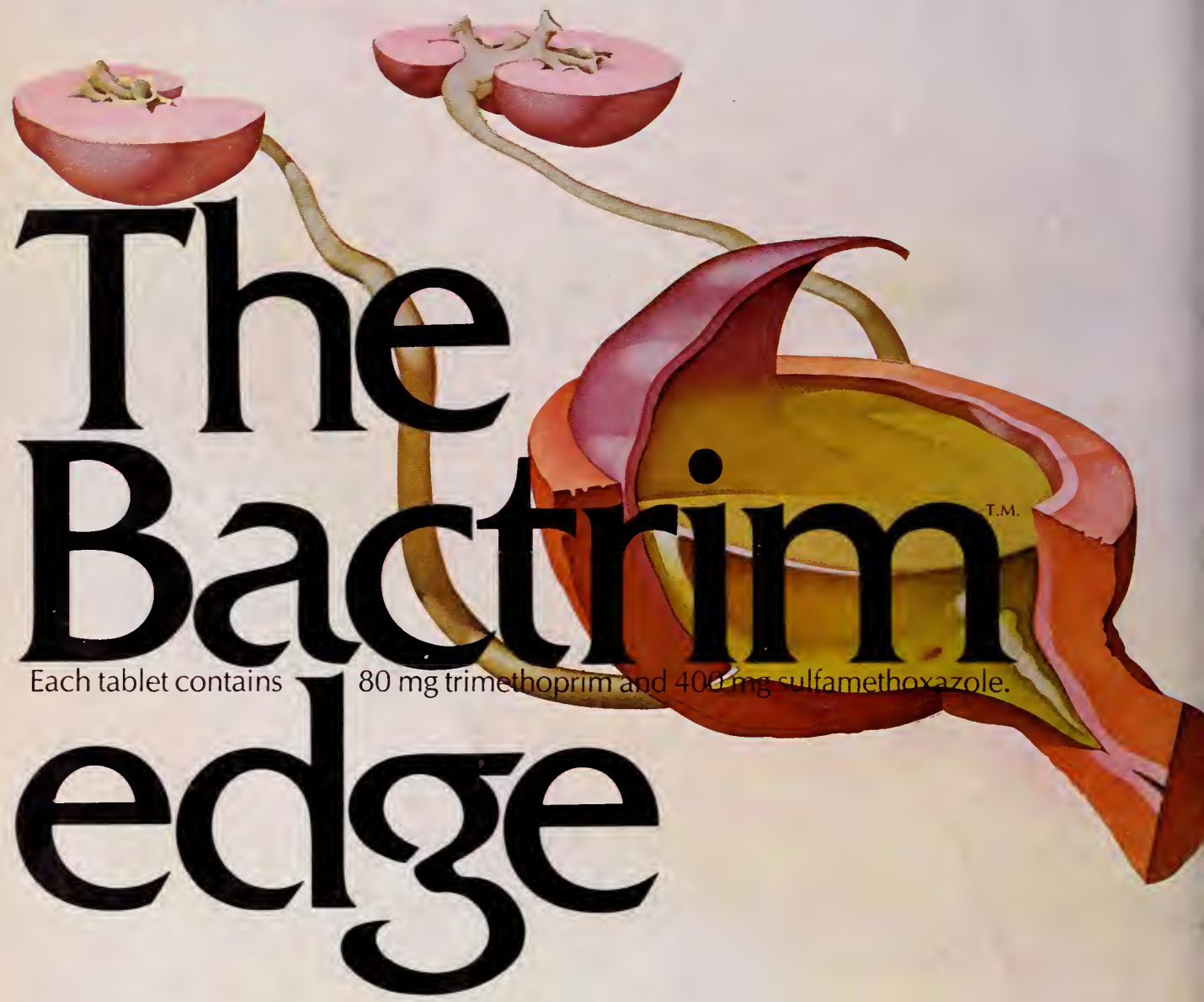

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The Nebraska Medical Journal

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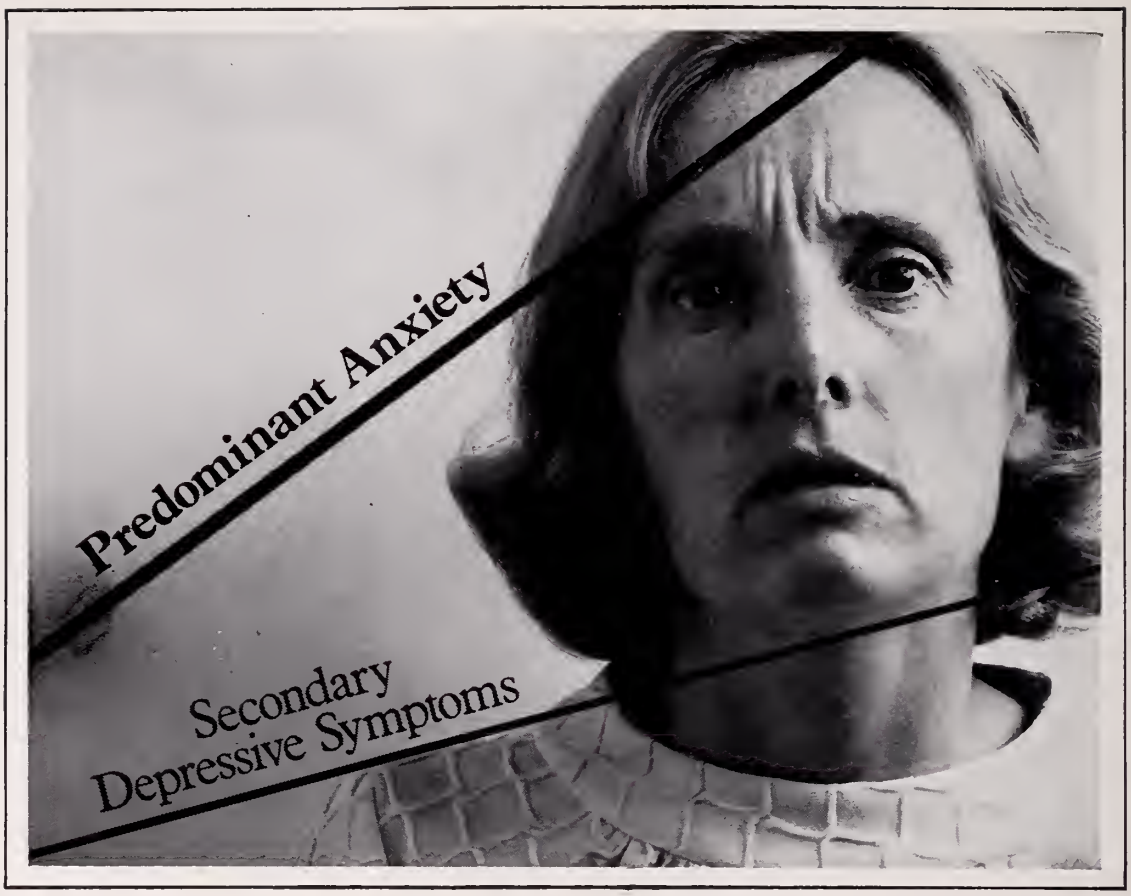

This psychoneurotic often responds

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

When you determine that the depressive symptoms are associated with or secondary to predominant anxiety in the psychoneurotic patient, consider Valium (diazepam) in addition to reassurance and counseling, for the psychotherapeutic support it provides. As anxiety is relieved, the depressive symptoms referable to it are also often relieved or reduced.

The beneficial effect of Valium is usually pronounced and rapid. Improvement generally becomes evident within a few days, although some patients may require a longer period. Moreover, Valium (diazepam) is generally well tolerated. Side effects most commonly reported are drowsiness, ataxia and fatigue. Caution your patients against engaging in hazardous occupations or driving.

Frequently, the patient's symptoms are greatly intensified at bedtime. In such situations, Valium offers an additional advantage: adding an *h.s.* dose to the *b.i.d.* or *t.i.d.* schedule can relieve the anxiety and thus may encourage a more restful night's sleep.

symptom complex to Valium® (diazepam)

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The Nebraska Medical Journal

EDITOR — FRANK COLE, M.D., 1845 "F" St., Apt. 1, Lincoln 68508 MAY 1974 VOL. 59, NO. 5
PHONE 475-3637

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Manuscripts to be presented for publication in the JOURNAL should he typewritten, double-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should he left free of typing. On the first or title-page should be shown the title of the article, the name (or names) of the author, his degree and other significant credits. Pages should he numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Illustrations should be numbered and their locations shown in the text. Each should be identified hy placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be in black (India ink) on pure white. Photographs should he on glossy paper and minimum of about 5 hy 7 in. in size. A legend should he provided for each illustration and, preferahly, attached to it.

Manuscripts (original, not a carbon) should be sent directly to the Editor at the Journal's address.

Letters to the Editor submitted for publication should be prepared as above, and must carry the notation: To be Published.

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Our Medical Schools . . .

Sickle cell

A sickle cell anemia screening and education program for over 10,000 persons, most of them children, got underway March 26 in Omaha, according to Dr. Frank M. Shepard, Chairman of the Department of Pediatrics at Creighton University School of Medicine. Creighton received funds for the program from the U.S. Public Health Service.

Dr. Matilda McIntire, Director of Creighton's Community Pediatrics Program, is coordinating the screening program with the Comprehensive Health Association (CHAO) and the administration of the Omaha Public School System. She said CHAO representatives are responsible for contracting and explaining the program. All testing is being done in the Omaha Public Schools. Preschool children and adults are being invited to participate at one of the 15 schools where testing is being conducted.

Adults tested and parents of children tested will receive a letter advising them of results. When necessary, persons will be contacted personally or by telephone. Individuals with other than normal test results are being advised to consult their family physician.

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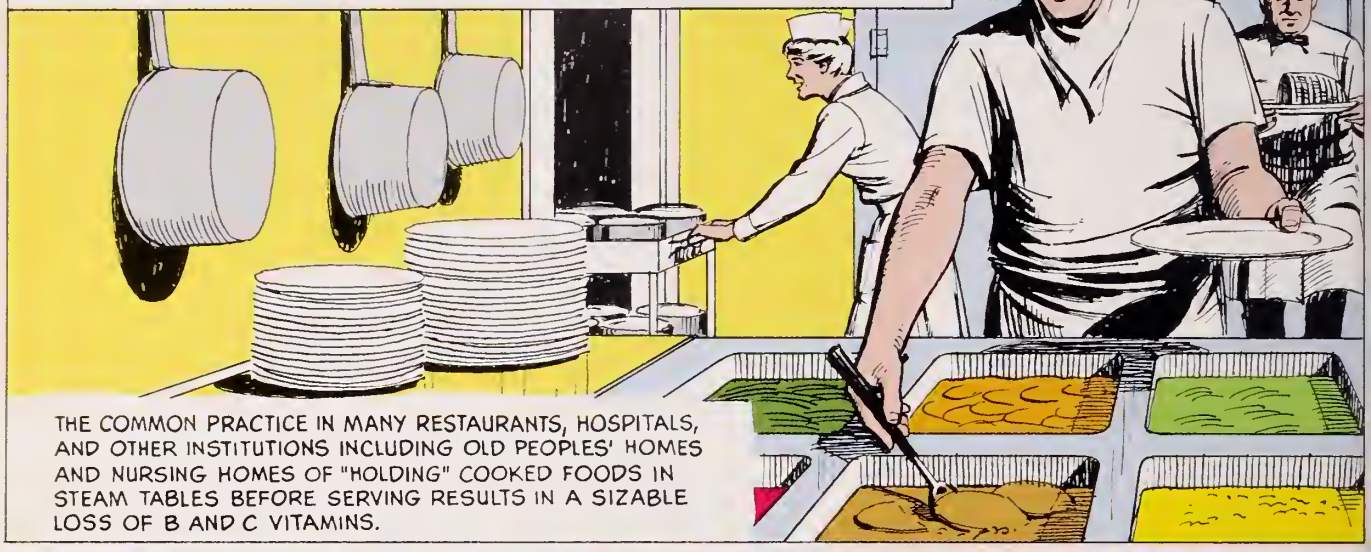

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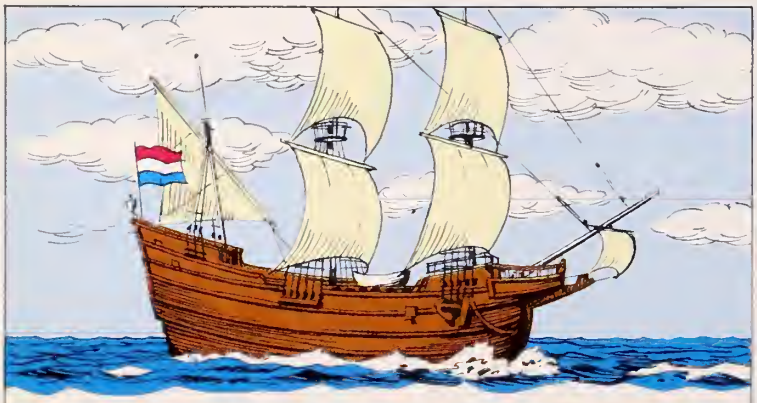

RONSSENS, A DUTCH PHYSICIAN, WROTE IN 1564 THAT "DUTCH SAILORS WHO, RETURNING FROM SPAIN, WERE ATTRACTED BY THE NOVEL RICHNESS OF THE FRUIT (ORANGES) AND BY THEIR GREED AND GLUTTONY, UNEXPECTEDLY DROVE OUT THE DISEASE (SCURVY), AND HAD THIS HAPPY EXPERIENCE NOT ON A SINGLE OCCASION ONLY, BUT REPEATEDLY."

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Creighton appoints

Dr. Joseph Holthaus, Dean of Creighton University's School of Medicine has announced the following appointments and promotions:

Appointments—

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Raymond G. Nemer, M.D., Clinical Instructor in Family Practice

Percy E. Jones, M.D., Clinical Instructor in Pathology

Arnold E. Schaefer, Ph.D., Clinical Professor of Nutrition

Promotions—

Sindhu R. Nayak, M.D., to Assistant Clinical Professor of Pediatrics

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Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

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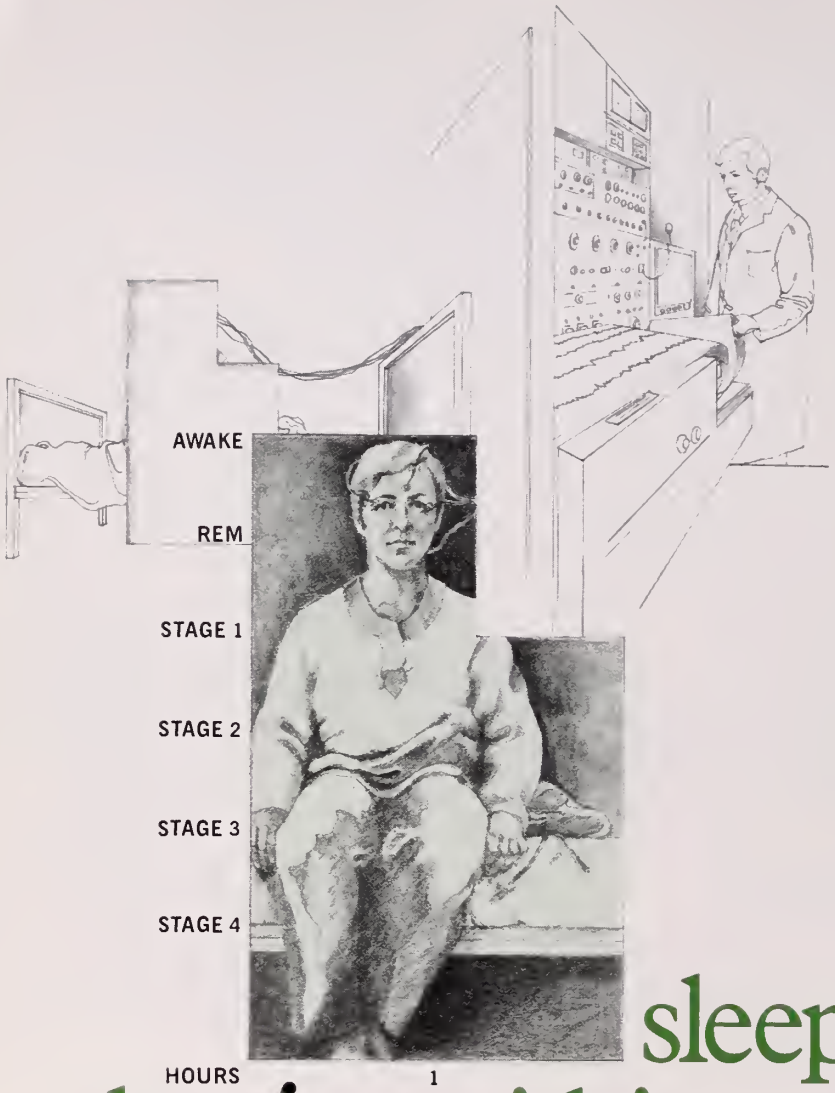

sleep begins within 17 minutes, on average ...

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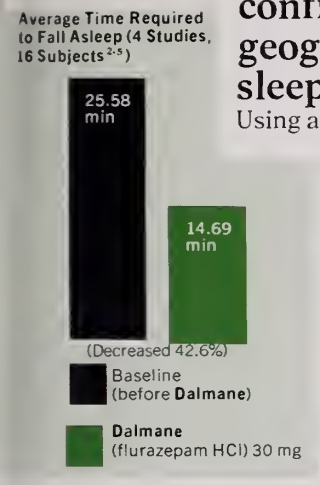
proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

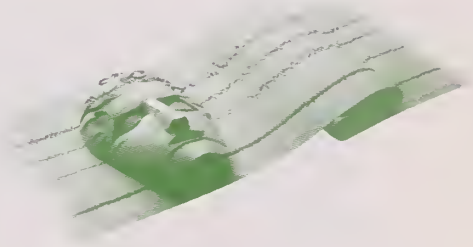
Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.
Contraindications: Known hypersensitivity to flurazepam HCl.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



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One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- sustains sleep 7 to 8 hours, on average, without repeating dosage

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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Opinion & Dialogue

Is there a need for a drug compendium?

Government Health Official

Henry E. Simmons, M.D.
Deputy Assistant Secretary for Health
Department of Health, Education and Welfare

A drug compendium of the type I envision would fill a definite need for the practicing physician. Such a compendium would give him all the information necessary for using a drug intelligently, and it would do so in a clear, concise, convenient, objective and balanced fashion.

What a Compendium Should Contain

I believe the compendium should inform the doctor what a drug will do, when he should use it for what type of patient, for how long, in what dose, what benefits his patient is likely to obtain, the risks involved, and cross-reactions with other drugs.

The information would be based on the package insert and have the same legal status. In fact a complete compendium with complete and current information might even eliminate the necessity

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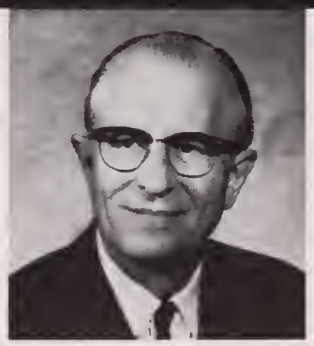

A drug compendium, or preferably compendia, should, I believe, be private, not federal, in sponsorship. They should contain comprehensive listings of drugs available for prescribing. They should be single, legibly printed volumes of reasonable size, updated quarterly or semiannually and completely revised every year

Function of a Compendium

A compendium should furnish the following information on drugs in the following order: indications for use, side effects, adverse drug reactions, contraindications, drug interactions, drug dosage and the dosage forms marketed. Drug prices should not be included because they vary so widely and change rapidly.

No compendium should set forth drugs of choice or discuss relative efficacy. Such questions must be left for the practicing physician to decide, whether on the basis of the medical literature, his own clinical experience, advice of colleagues, information supplied by manufacturers, and so on.

Nor should a compendium undertake to educate the doctor on how to use drugs. Rather, it must be a reference source designed primarily to refresh his memory as to drugs he may not use regularly. It

r a package insert in many in-
ances. This would constitute a
ubstantial saving for the manu-
cturer.

By a complete compendium,
do not mean a volume of prohibi-
ve size. You don't need a book
escribing 25,000 products with
n enormous amount of repetition.
ather, drugs should be arranged
y class. Mutually applicable infor-
nation would be provided, along
ith brief discussions pinpointing
ifferences in specific drugs of
at class. Listings would be cross-
ndexed in a useful way.

ther Available Documents as ources of Information

Existing references such as
DR and the AMA Drug Evaluation
re obviously useful but they are
ncomplete. Either they are not
ross-referenced by generic name
nd do not group drugs with simi-
ar characteristics, or they do not
st all the available and legally
narketed drugs. And some of
hose omitted may be very useful.

On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

---

hould in no way imply control over
he practitioner's prerogatives.

Why Another Compendium?

A practicable, single-volume
compendium cannot, nor is it
necessary to, include all drugs on
he market today. From my prac-
ice of internal medicine for some
5 years, my experience as a con-
sultant, and as a faculty member
f four or five medical schools, I
vould estimate that a doctor uses
nly 30 to 35 drugs regularly. The
972 Physicians' Desk Reference,
ncidentally, contained about
,500 entries.

As to whether there should be
a federal compendium, in my opin-
on, as stated earlier, the answer is
easy—there should *not* be one. The
roposal assumes that existing
compendia are inadequate. We're
not sure of that at all. Whatever its
mperfections, the present drug
nformation system in the U.S. is
pen, multifaceted, pluralistic and
extensive. Good compendia exist,
as well as other ample sources on
drug therapy, ranging from journal
literature through AMA Drug Evalu-
ation to company materials. Not
all physicians may use such
sources as often or as well as they
should, but that is the fault of the
man, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

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P·M·A

Medicinews . . .

Cancer act extension

By a vote of 89 to 0 the Senate has passed S. 2893, the National Cancer Act Amendments of 1974, a three-year extension of the National Cancer Act. Under the Senate-passed bill there would be no specific limit on the number of cancer research centers which could be established under the program. The present limit is 15, but it has been suggested that 30 to 35 such centers may be required. The bill would also establish a President's Biomedical Research Panel composed of the Chairman of the President's Cancer Panel and four members appointed by the President who are qualified to appraise biomedical research programs of the National Institute of Health. The Panel would monitor the development and execution of the biomedical research programs of NIH and would report directly to the President. It would report any delays or blockages in the execution of such programs, submit periodic progress report and annually evaluate the efficacy of the research efforts within NIH.

The House Interstate and Foreign Commerce Committee has reported a similar three-year extension, H.R. 13053, the National Cancer Act Amendments of 1974.

National workshop on teratogenesis and Mutagenesis, June 17-21, 1974

An interdisciplinary workshop cosponsored by the Food and Drug Administration, Teratology Society, and Jefferson Medical College for discussing and demonstrating the various problems encountered in teratologic and mutagenetic investigations. Areas of study included in this week-long workshop will be basic concepts of teratogenesis, mutagenesis, transplacental carcinogenesis as well as cytogenetics, epidemoiology, statistics, pharmacology, biochemistry, and drug testing. For further information and applications write to: Ronald P. Jensh, Ph.D., Jefferson Medical College, 920 Chancellor Street, Philadelphia, Pa 19107.

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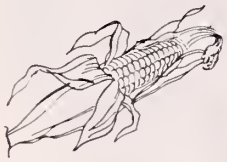

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Otolaryngologic assembly of 1974

The Annual Otolaryngologic Assembly of 1974 will be held October 26 through November 1, 1974, in the Eye and Ear Infirmary of the University of Illinois Hospital. The Department of Otolaryngology of the Abraham Lincoln School of Medicine, University of Illinois at the Medical Center, offers a condensed basic and clinical program for practicing otolaryngologists under the direction of Emanuel M. Skolnik, M.D., with Burton J. Soboroff, M.D., as co-chairman. This program is designed to bring to specialists current information in medical and surgical otorhinolaryngology. Write to: Otolaryngology, P. O. Box 6998, Chicago, Illinois 60680.

A separate, but correlated course, "Conference on Radiology in Otolaryngology and Ophthalmology" will be held this year on Friday and Saturday, November 29 and 30, under the guidance of Galdino E. Valvassori, M.D. For further information about the radiology conference, write to Professor Valvassori, Radiology Department, Abraham Lincoln School of Medicine, P. O. Box 6998, Chicago, Illinois 60680.

Long-term care proposed

Representative Barber Conable (R., N.Y.) has introduced H.R. 13720, the Medical Long-Term Care Act of 1974. In his introductory remarks, Congressman Conable said his bill would establish "a new program under Medicare which would provide protection against the costs of long-term care, both institutional and noninstitutional, without concern about drawing an arbitrary and unnecessary line between health care services and nonhealth care services." The bill calls for the creation of long-term care centers in all communities. These centers would coordinate services and administer financial transactions. The program would be voluntary and would be financed through a combination of a $3.00 per month premium paid by those who choose to enroll in the program, a state contribution of 10% of the program cost, and the balance from federal general revenues.

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*Data on file, Hoffmann-La Roche Inc., Nutley, N.J

The lesions on his face are solar/actinic— so-called "senile" keratoses... and they may be premalignant.

Solar, actinic or senile keratoses

These lesions may be called by several names, but they usually can be identified by the following characteristics. The typical lesion is flat or slightly elevated, of a brownish or reddish color, papular, dry, rough, adherent and sharply defined. They commonly occur as multiple lesions, chiefly on the exposed portions of the skin.

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Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

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Rapid Identification of Acute Drug Intoxications — J. Carruth et al (Dept of Pharmacology, Johns Hopkins Univ School of Medicine, Baltimore 21205). Johns Hopkins Med J 133:148-155 (Sept) 1973.

Mass spectrometry was used for rapid identification of drugs found in gastric aspirates of some victims of accidental or deliberate drug overdose. The analyses were performed on patients who were comatose, or who did not respond to treatment in the expected manner. In 73% of the 63 patients a positive identification was made; in 19% the sample was found to be free of any drug, and in 8% of the patients a drug was detected but not identified. In 44% of the patients mass spectral analyis confirmed the physician's diagnosis. In 29% new information was provided to the physician about the identity of the toxic agent.

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The life span is greater in Nebraska than in any other state; or to put it another way, Nebraskans live longer than all other Americans. The average longevity is 71.2 years for the nation; ours is 71.95.

That's one percent longer than the average, but it's a whole three quarters of a year, or nine months. And remember, it's not only larger than the national average, it's the biggest of all the fifty states. We're at the very top of the list.

Until now, nobody has said why this is so. But I know. It's not the climate, or original settlers, or less alcohol, or locally grown food, or our politics.

It's because we have the best doctors in the country.

And the best medical journal.

—F.C.

ARTERIES DON'T GO ANYWHERE

The inferior laryngeal artery ascends upon the trachea, says my big anatomy book. The ophthalmic artery goes through the foramen opticum, reads my hand-atlas. The inferior vena cava ascends in front of the bodies of the lumbar vertebrae. The mandibular nerve runs downward through the foramen ovale. Lymphatic vessels enter lymph nodes and pass to other lymph nodes.

The thoracic duct enters the throax through the aortic hiatus of the diaphragm. The cystic duct runs backward, downward, and to the left from the neck of the gallbladder. The spinal cord goes over between the atlas and the occipital bone.

Arteries don't go anywhere; and neither do veins, lymphatic vessels, nerves, or ducts. Blood flows to different parts of the body and back, lymph and chyle move, and nerve impulses go to muscles and glands, and from things that feel. But the structures that conduct blood, lymph, neural impulses, and chyle don't move; they just lie there. Is it a matter of semantics to say that arteries move? I do not think so.

Does it make for easier learning to believe that nerves go places? This cannot be so; we teach and learn untruths. A nerve does not run down through a foramen, it just stays where it is. And the spinal cord isn't going anyplace.

I wonder if anatomists have tried to teach anatomy honestly, without pretending that stationary things are really moving. If it is a useful teaching device, it is possible that the untried method of teaching correctly is better, that arteries, nerves, lymphatic vessels, veins, and ducts do not move; blood, lymph, impulses, and chyle move.

I offer equal time to the anatomists.

—F.C.

WHAT CAN HE DO?

Medical reports are often hopelessly technichal, and while they tell us more than we want to know, they say too little. They do not conjure up the image of the patient. They substitute reams of meaningless figures for the few simple important things the reader wants to know.

What can the patient do? Can he make a fist? Can he stand; can he walk? Can he see; can he hear? Can he feel, is he able to smell? Can he get his breath? Can he lift? Can he put on his shoes and stockings?

Does he fall? Does he cough? Can he get out of bed?

Can he bend? Can he get up? Can he turn over? Can he speak? Does he understand? Can he write? Is he able to swallow?

How fast does he breathe? I think that is better than 30 confusing pulmonary function tests that change every few years and drive you to the reference books (I wrote one myself) to see what is normal. Can he

talk without stopping for breath after every half-sentence? Can he count?

I'd like to know simple things that have to do with everyday life, since we live everyday lives. Can he tie his shoelaces? Can he cut his meat? Does he laugh; does he make sense? Can he dress himself? Is he in pain?

I *like* numbers. But I'd rather know how far he can walk, than that something is 14.55; and is he pale, or blue, or ruddy? Can he blow out a match?

Can he bathe himself, and is he otherwise all right in the bathroom? Can he read?

Can he comb his hair? Can he feed himself? That's what I want to know.

—F.C.

COLE'S COMMON COLD CALCULATION

If you want to know how many colds you will have each year, just deduct one fifteenth of your age from five.

Or subtract your age from 75 if you can still do it, and divide *that* by 15.

If you come down with a cold that you're not supposed to get, according to my formula, tell me. I'll change the formula, or I'll report it to the government, and they'll stop the cold.

Or you can always give it to somebody else.

—F.C.

WHAT HAPPENS WHEN YOU DIE

We don't die all at once.

Little pieces of me may die, when I do not. When my toe becomes gangrenous, my toe dies, but when do I die? And when I die, what happens to the parts of me?

The heart stops when you die. The right atrium has been called the ultimum moriens, because it was supposed to be the last part of the body to cease moving in death. And breathing stops, usually before the heart.

The senses may not go at the same time, and there is a theory that a dying person can hear what the mourners say. The brain dies, of course. The hair and nails are supposed to grow for a while, since their metabolism is sluggish and they do not get the message for a long time; the brain dies quickly and the nails slowly.

Discoloration of dependent parts sets in, known as livor mortis or postmortem lividity. Postmortem clots form. Cyanosis may occur, but I have sometimes seen better color in the morgue than in the operating room. Rigor mortis is evident. The spleen contracts greatly, so that the living spleen may be five times as large as the dead one. And so does the sigmoid colon, I think, because anatomists say it is shorter than the surgeons believe, only some four inches long.

The pupils dilate. The eyes close, but they used to put pennies, and before that, obols, on the eyelids. The skin becomes cold, and does not bleed when cut. The jaw drops, and the mouth falls open.

Then you are dead.

—F.C.

ON WEIGHING YOURSELF

Height-weight tables are useless unless they tell you if you are supposed to be fully clothed, partly dressed, or bare-naked. Partly dressed is undefinable; and fully clothed depends on sex, season, and weather; fully unclothed is best of all.

If you are an accuracy fanatic, you will want to subtract for your eyeglasses, and for being dripping wet if you have just stepped out of the shower. I am not that fiendish, but my scale is, so I have to weigh myself five times and multiply by two to get a good reading, what with my glasses down at the end of my nose, because my eye-focusing is not at its best at early-morning weighing-in time.

After you have guessed at clothing, and pretended you are taller than you are, you have to contend with what is laughingly called frame, which passeth all understanding. My weight is all right, I just need less height and more frame.

I get onto the weighing device, step down and eat my breakfast, and find I have lost a pound and a half. Or what is worse, I measure my avoirdupois, leave the room, then return and get up on the devilish device and find I have gained two pounds.

Scales used to issue tiny printed messages, like Chinese fortune cookies. I miss those little cards, but when my bathroom scale which I keep in the kitchen, because of the hard floor and the fridge, tells me I have gained five pounds, it tells me my fortune, too.

Weigh yourself every day. Once a week is enough for your height.

—F.C.

ON BEING SCIENTIFICLE

Ossicles are tiny bones, but why is everything else little in the human body? There is the seminal vesicle, and other vesicles. There are utricles, and four auricles; and there are six ventricles, four in the brain and two in the heart. There are red and white corpuscles, and there are radicles. There is a caruncle, a cuticle, and we even have vehicles.

Among nonmedical things, there is the barnacle, the icicle and the popsicle, the oracle, the binnacle and the pinnacle, the pentacle and the tentacle, and the canticle.

Murmurs are apicle, and we are logicle.

Two things disturb this editor: the testicle and the article. Does everything have to be little?

—F.C.

THE BIG BOOK

Books are cheap. It takes 5 years to write one, and you can buy it for $10. I own one or two hundred books, and I have read most of them, and I use all of them. But when I want to find something, I have to consult a hundred indexes in a hundred books to find it. So I have come up with the wonderful idea that everything ought to be contained in one big book. It reminds me of the story of the farmer who had 8 haystacks in one place and 4 in another and put them together and then had only one. Spencer tried to rewrite everything, but not in one book.

It makes me think of the man on the island who had years to think and who wrote all the wisdom in the world in a long poem. And as time went by, while he was waiting to be rescued, he condensed the long poem into a short one, then into one line, and just before help came, into a single unprintable word.

Lawyers have as many books as doctors, even more, but we don't have time to look things up in the middle of an operation. All of this reminds me of Thoreau, who had his house filled with his own unsold books, and when someone complimented him on having so many books, Thoreau said yes, and he had written most of them himself.

It would be nice, and in this day of miniaturization even possible, to get everything written or at least worthwhile into one big book, so that we would need to look at one book, and pore through only one index. All of this may not be probable, but it is at least possible, and it is pleasant to think of. One could look up torts, and hepatitis, and Shakespeare, and Chopin, and the Big Dipper.

It would be a nice big book.

—F.C.

AND HIS MOTHER

Doctors die differently; and when, where, and how they die warrants more study than has been done.

Women generally outlive their husbands for two reasons: females live longer than males, and wives are usually younger than their mates.

So when I write a physician-obituary, the survivors often begin with the wife, and that is not too remarkable.

But the list often contains these three words that give me pause, and reflect on the not too easy life of the doctor.

"And his mother."

—F.C.

Health Education Issues for the University Of Nebraska Medical Center, 1973-1974

ROBERT D. SPARKS, Chancellor*

I am pleased to report to you on programs at the University of Nebraska Medical Center. You are aware that we now have responsibility for the development of the educational programs of the Colleges of Nursing and Pharmacy in addition to the College of Medicine which preceded them on the Medical Center campus in Omaha. We have also assisted the College of Dentistry in the establishment of hospital and outpatient experiences for dental students on our campus. Because of the special interest of the Nebraska Medical Association, I will emphasize what is happening primarily in the College of Medicine of the University of Nebraska.

The number of places in the entering class of medical students will remain unchanged at 145 students in the immediate future, but we constantly review our projections for future enrollments. We seek to enlarge the number of positions in the total residency program, since we believe residency training in the state is critical to attracting physicians to practice medicine in Nebraska. We gather data about the number of physicians available or needed from the Nebraska Medical Association's office, from the Medical Licensure Board, and from communities over the state in assessing our enrollment plans.

We coordinate our planning for enrollments in all the health education programs with Creighton University through the mechanism of the Creighton-Nebraska Universities' Health Foundation. The two colleges of medicine also use this Foundation to review the developments in their educational programs, and attempt in this way to utilize faculty of both colleges for the benefit of students at both colleges.

Pressures on the financial support of our College of Medicine are similar to the pressures on the medical schools over the country. The governmental support to expand enrollments in medical schools may not be sustained. At the state level, tax support has been decreased and income from professional service substituted. At the federal level, new legislation is needed if approximately two million dollars of educational support is to be available each year to the University of Nebraska College of Medicine. Furthermore, recommendations from national foundations and governmental agencies seek to increase tuitions paid by students and their families for enrollment in state colleges and universities. In summary, these trends diminish tax support dedicated to the educational activities and substitute income from professional services instead.

Involvement of the College of Medicine in care of patients must be primarily to assure clinical educational experiments of the students in our programs. We have extended our affiliation with hospitals throughout the state in order to anticipate requirements for the expanded number of medical students and residents. These clinical opportunities must also include supervised care of patients in an ambulatory setting comparable to the usual medical practice.

The University of Nebraska Medical Center clearly sees its educational responsibilities responding to the needs of the State primarily. By contrast, our sister Health Science Center at Creighton University responds primarily to national and regional interests. Within these concepts, the two medical centers can and do work together in the development of their programs.

The University of Nebraska Medical Center and the Nebraska Medical Association have worked cooperatively in this last year in the interest of improving medical education and care in the State. I am confident that in the coming year, this cooperation will continue and we can mutually strive to meet the challenges that face Medicine.

*Presented at the President's Dinner, Lincoln, Nebraska, September 15, 1973.

Genotypic Variations In Caucasian Leukocyte Estradiol 16 Hydroxylase Activity: A Measurable Determinant Of Breast Cancer Risk?*

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OVARIAN secretion of estrogenic hormones for 10-15 years after puberty appears to be a necessary prerequisite for breast cancer development. However, until the present time there has been no evidence for any quantitative increase in the secretion rate of estradiol 17B in women with either chronic fibrocystic disease, or with breast cancer, to explain why about 6% of Caucasian women will develop breast cancer in their lifetime, and up to 40% develop benign breast disease. Until recently, no one had considered the possibility of defective metabolism of estradiol 17B, which might prolong its carcinogenic activity upon target tissues such as the breast or uterus. In 1966, we reported significantly reduced urinary excretion of estriol in 21% of healthy women and in 62% of untreated breast cancer patients, estriol being one of the two primary oxidative metabolites of estradiol produced by tissue estrogen metabolism, neither of which are carcinogenic for the breast.[1]

Urinary estriol excretion varies widely among pre-menopausal Caucasian women. We have suggested that several genotypes for estradiol oxidation may exist, accounting for three phenotypes exhibiting low, intermediate and high urinary excretion rates for estriol/estrone + estradiol, observed by several investigators using different analytic methods in premenopause Caucasian women.[2]

In this preliminary report, we are describing three statistically distinct biochemical genotypes for estradiol oxidation to estriol, determined from incubation of leukocyte concentrates from peripheral blood samples. These findings may be representative of a widespread mutant genotype involving all body tissues capable of inactivating estradiol to less carcinogenic estriol derivatives, and hence predictive of breast cancer risk.

Methods:

Sixty ml of venous blood was drawn into a plastic syringe containing 1,000 units heparin, and three ml aliquots were discharged into other tubes for complete blood cell and platelet counts. The blood was sedimented for 20 minutes at about 1,500-2,000 r.p.m. in conical tipped plastic centrifuge tubes and the supernatant serum and 90-95% of the packed red cell mass withdrawn by a glass capillary pipette. In some experiments, 50-100 mgm of fibrinogen in 0.9% NaCl were added, and the buffy coat was isolated by gravity sedimentation within the syringe itself; leukocytes nearly free of erythrocytes could be isolated by ejecting the plasma followed by the buffy coat into separate tubes. Five to 8 ml of leukocyte rich buffy coat was added to an equal volume of Krebs-Ringer PO_4 buffer pH 7.4 containing glucose 200 mg.%, which was then equally distributed to four 25 ml flasks, each containing NADPH 1.0 mg., nicotinamide 10 mg. and Ampicillin 10 mg. To one of the duplicate controls, 2 mcg of nonradioactive estradiol 17B was then added, and the second control flask was heated to 80° C. for 5 minutes. Approximately

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0.5×10^5 d.p.m. of 6-7 ^{3}H estradiol 17B (New England Nuclear) was then added to each of the four replicate flasks, which were then incubated aerobically for 24 hours at 37° C. in a Dubnoff shaking incubator. Four volumes of acetone were added to the flasks to precipitate proteins and to terminate oxidation. After removal of the acetone from the centrifuged sediment, three ether-chloroform (3:1) extracts were performed of acetone concentrates followed by a final ether extraction. The pooled extracts were vacuum distilled to dryness and the residue taken up in 0.3-0.5 ml of methanol. The extracted steroid metabolites were chromatographed using thin layer silica gel (Brinkman #254) in a 5% ETOH 45% cyclohexane 45% ethyl acetate liquid phase, against authentic reference non-radioactive 2-OH estriol, estriol, 16 epi-estriol, 17 epi-estriol, 16, 17 epi-estriol, 16-OH estradiol, estradiol 17B and estrone. The zones of migration of metabolites were mapped using ultraviolet light and traced upon paper for a permanent record. The total migratory strip for each of the four extracts from a single experiment chromatographed on a plate was then removed segmentally according to the migration zone of each of the reference compounds, by scraping off the silica gel into individual counting vials containing 10 ml of PPO - POPOP fluors, prepared after the method of Herberg.[3]

Each vial was then counted for 10 minutes in a Unilux II liquid scintillation spec-

TABLE 1

Net Percent Leukocyte Estradiol 16 Hydroxylase Activity/mg DNA

E.H.	♀*	0.5	E.M.	♀	3.2	N.V.	♀	7.7
H.B.	♀*	0	B.S.	♀*	1.9	A.K.	♀	11.2
E.C.	♀*	0.9	A.K.	♀	2.7	J.O.	♀	10.0
H.T.	♀	0	W.C.	♀	1.3	T.G.	♀	11.6
H.B.	♂	0	K.H.	♂	2.1	S.R.	♀*	14.2
H.P.	♀*	0.5	S.G.	♀	1.5	G.K.	♀	16.4
R.N.	♀*	0	W.G.	♀	1.5	H.B.L.	♀	9.2
E.H.	♀	1.0	R.L.	♀	3.0	B.G.	♀*	9.0
			F.J.	♀*	3.6			
			H.R.	♀	1.5			
			H.L.	♀*	1.5			
			J.L.	♀	2.8			
			S.R.	♀*	3.9			
Mean		0.4			2.3			11.1
S.D.		0.2			0.9			2.7
S.E.		0.07			0.03			1.0
S.E. diff.			0.26			1.0		
t			7.3			8.8		

*Carcinoma of breast

*Other carcinoma or sarcoma

trometer with a counting efficiency in the range of 26% for tritium. The total counts per minute from each unknown migratory strip were obtained from the sum of those representative of the silica gel segments removed, and the percentage of each metabolite calculated. The net percentage of each metabolite was determined by subtracting the mean percent of each segmental c.p.m. of the two control incubations, from the mean percent c.p.m. obtained from identical areas of the two test incubates. The net percent of each metabolite obtained, and their sum, was expressed as the percent conversion of ^{3}H-estradiol 17B, per mg. mean DNA present in the leukocyte residues from each of the four extracts.[4]

Observations:

Preliminary experiments indicated that plasma and erythrocytes yielded no net 16-hydroxylation of tritiated estradiol. Buffy coat leukocyte preparations from different individuals showed a wide variation in 16-

TABLE 2

REPRODUCIBILITY OF LEUKOCYTE ESTRADIOL 16 HYDROXYLASE

ACTIVITY MEASURED AT DIFFERENT TIMES

Pt.	Sex	Date	Net % Activity; Per mg/DNA (Uncorrected)	(Corrected)
M.K.	♀	11/27/72	1.7	
		11/29/72	1.5	
H.B.	♀*	12/19/72	0	
		4/25/73	0	
S.R.	♀*	1/2/73	22.3	
		1/22/73	5.0	3.9
H.L.	♂	8/25/72	5.9	
		11/13/72	7.0	

TABLE 3

ASSOCIATION BETWEEN CARCINOMA OF BREAST AND MUTANT

GENOTYPE FOR LEUKOCYTE ESTRADIOL 16 HYDROXYLASE

(FEMALES ONLY)

Genotype	Range of leukocyte estradiol hydroxylase (%) per 100 mcg. DNA	Breast cancer diagnosed	No breast cancer diagnosed	
hh (homozygous mutant)	0-1	5 (2.6)	2 (4.4)	7
Hh (heterozygote)	1.1 - 5	3 (4.5)	9 (7.5)	12
HH (intact homozygote)	5.1 +	1 (1.9)	4 (3.1)	5
		9	15	24

Figures in parenthesis represent expected no. cases in each subdivision; $x^2 = 5.01$.

hydroxylase activity varying from zero to a major percentage of the ^{3}H-estradiol substrate. When the percentage of total 16-hydroxy metabolites was corrected for the leukocyte DNA present, three sub-groups of hydroxylase activity were distinguished in both sexes, whose mean values were statistically distinct (Table 1). The t value for the standard error of difference of each of these means was 7.3 - 8.8 ($p < .001$). Repeated observations of leukocyte hydroxylase activity from several individuals indicated a reasonable degree of reproductibility (Table 2).

Assuming that the specimens with least hydroxylase activity represented homozygous recessive mutants with impaired hydroxylase activity (hh), while those with the highest activity were intact homozygous alleles (HH), lacking any impairment of estradiol oxidation, estimates of Mendelian assortment of alleles could be performed in a few families (Fig. 1). With a single exception, they are suggestive of genetic inheritance similar to that observed in other inherited deficiencies of steroid metabolism.

The incidence of unilateral and bilateral primary carcinoma of the breast in the tested population was suggestively greater among those whose leukocytes demonstrated the least oxidative activity for estradiol 17B (Table 3). Furthermore, the distribution of the mutant genotype in this population, 56%, was closely similar to the estimated gene frequency previously obtained from urinary phenotypic analysis (50%). A correlation between deficient leukocyte estradiol oxidation to estriol epimers, and "subnormal" fractional urinary excretion of estriol/estrone + estradiol, however, has not yet been established.

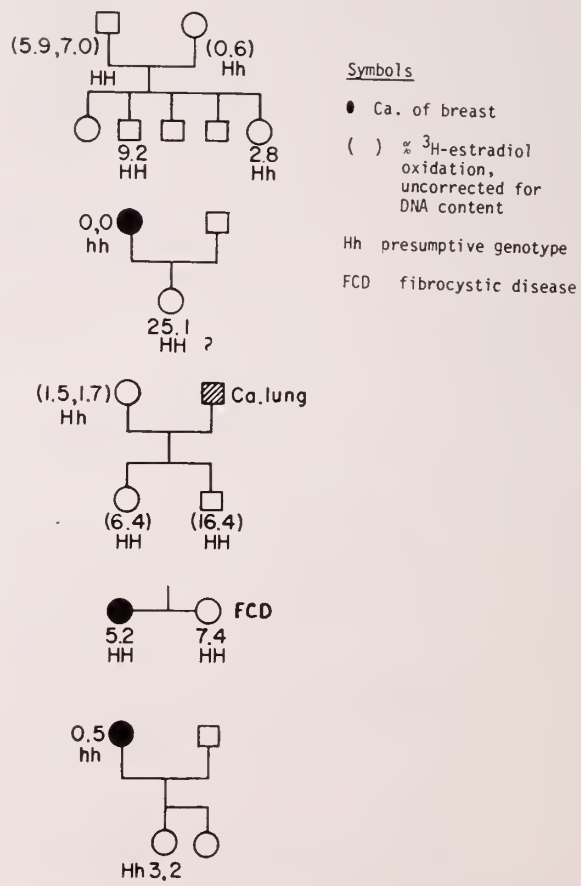
Discussion

This is the first report of estradiol 17B oxidation by human leukocytes. Previous investigations have identified estradiol oxidation in placenta and fetal human liver. Estradiol 17B is the principal estrogen secreted by the human ovary, which interconverts readily and reversibly with estrone in peripheral body tissues; both of these steroids are potent rodent mammary carcinogens. Their access to mammary tissues is dependent entirely upon binding to a high affinity, low capacity cytoplasmic estrophile receptor protein, to which estriol and its epimers actively compete for binding.[5] The latter are far less carcinogenic and exert a well-recognized inhibitory action upon estrogenic stimulation,[6] including carcinogenicity.[7]

Caucasian women who are homozygote recessive mutants (or to a lesser extent heterozygotes) for leukocyte estradiol hydroxylase activity are believed to have a cellular defect in oxidative activity common to the mixed function oxidase system heretofore associated with the endoplasmic reticulum of hepatic and small intestine epithelial cells. These tissues are the sites of highest enzymatic activity in the rat[8] and also for oxidative activity inactivating exo-

Figure 1

LEUKOCYTE ESTRADIOL 16 HYDROXYLASE ACTIVITY IN GENETICALLY RELATED INDIVIDUALS



genous carcinogens such as benzpyrene and many drugs. Benzpyrene hydroxylating activity has been found recently in human leukocytes.[9, 10]

Decreased rates of estradiol hydroxylation to estriol in some women may subject the estrogen target tissues to a more intensive chronic carcinogenic stimulus, thereby contributing to the incidence of breast carcinoma in Caucasian women, which remains the principal cause of female death in this race between 45-55 years of age. The extremely high prevalence (50-56%) of the mutant allele in Caucasians probably reflects its appearance in European Caucasians many centuries ago. The mutation carries little unfavorable biologic influence since it impairs reproductive activity only slightly, estriol being generated directly from dehydroepiandrosterone secreted by the adrenal cortex during pregnancy. The lethal effects of the mutation on its carriers is chiefly manifest after the child-bearing period has passed.

Extension and confirmation of these observations may make it possible to pinpoint much more accurately early in life, those Caucasian women most likely to develop breast cancer. Chronic estriol substitution therapy has been proposed as a possibility for the highly susceptible homozygous recessive mutants with least estradiol hydroxylation activity to prevent undue breast cancer risk by simulating and extending the protective action of saturation of tissue estrogen receptor proteins with estriol, comparable to physiologic changes associated with pregnancy.[7]

Summary:

Three biochemical genotypes for leukocyte estradiol 16 hydroxylase activity have been described in Caucasian males and females with and without cancer of the breast. These are consistent with a previously postulated autosomal recessive allele impairing the mixed function oxidase system associated with cytoplasmic endoplasmic reticulum, which carries on the oxidative degradation of androgenic and estrogenic steroids, exogenous polycyclic hydrocarbon carcinogens and numerous drugs used in every day clinical practice. The mutant genotype has been noted more frequently in breast cancer patients than in non-cancer patients and well individuals tested thus far.

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ADDENDUM:

Data have been obtained from 99 cases, 47 performed in duplicate. In two thirds of duplicate analyses, median variance was less than one percent. Frequency analysis of the hydroxylating activity now suggests phenotypes with 0-2 percent, 2-15 percent, and over 15 percent metabolite formation. These phenotypes were consistent with Mendelian inheritance in 10 out of 12 children, whose parental phenotypes were ascertained. Leukocytes from 18 of 31 breast cancer cases (58%) exhibited absent or low estradiol hydroxylating activity.

Cancer Resistance: Part I*

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Introduction

CANCER is not uniformly distributed in the population. There are marked variations in cancer incidence at different anatomic sites, in different populations and in different areas of the world. Numerous etiologic differences account for such variations in cancer incidence, including differences in genotypes, environmental exposures, habit patterns, occupations, socioeconomic status, and educational factors.[1, 2] A comprehensive exploration of cancer etiology involves integrated consideration of all potentially mitigating factors, not only individually, but also collectively as they interact with each other.[1-5]

As we studied families with significantly increased incidences of cancer, compared to the general population, we observed a significant paucity of occurrences of cancer in certain branches of these families and in a number of other families, some of which included the kin of spouses of patients in high-incidence families. We concluded that some kindreds may be characterized by unusual resistance or decreased susceptibility to cancer, just as other kindreds may be characterized by unusual cancer - proneness. This observation is not surprising because significant differences in cancer resistance have been well established in inbred strains of a variety of animals.[6-8] Recent studies in tumor immunology have revealed a crucial relationship between an animal's immune defense system and its response to carcinogens as well as to transplanted cancer cells.[9, 10] Stephenson, *et al*[11] have discussed spontaneous regression of tumors in humans in relation to tolerance and/or resistance to malignancy.

Several examples of possible cancer resistance will be discussed. They will include: (1) two families noteworthy for a paucity of carcinoma wherein no other known associated genetic trait or disorder has been identified; (2) data on an autosomal dominantly inherited disorder, namely, osteogenesis imperfecta which seemingly shows a paucity of cancer in affected individuals; (3) a discussion of cancer variations in diabetes mellitus, a condition known to be familial but for which the genetic mechanism has not yet been determined; (4) cancer frequencies in patients manifesting a deficiency of the enzyme glucose-6-phosphate dehydrogenase (G-6-PD); finally (5) we shall present data showing cancer frequency variations in a normal population in Part II of this paper.

(1a) Cancer-Resistant Family (Family A)

The schematic pedigree shown in Figure 1 is noteworthy for a paucity of malignant neoplasms. Interestingly, longevity was rather advanced in many of its members. The average age at death of all members was 57.4 years. When deaths below age 30 were excluded, the average age at death was 70.3 years. Cardiovascular disease was responsible for 12 of the 32 recorded causes of death at ages which ranged from 53 to 86. Two family members are living in their eighties and seven in their seventies. The histologic varieties of cancer in several patients, significantly, were usually associated with non-genetic factors, i.e., bronchogenic carcinoma in a heavy smoker (Table 1). Thus, in this family we see that among 266 relatives at risk for cancer, only five have developed malignant neoplasms. In considering those who reached the age of 40, 3.5 percent developed cancer (Table 1).

*Portions of this material are reprinted from **Cancer Genetics**. Editor Henry T. Lynch, M.D., in press, by permission of Charles C. Thomas, Publisher.

(1b) Cancer-Resistant Family (Family B)

Among 589 members of Family B, 16 have developed cancer (2.7 per cent, Figure 2, and Table 2).

When each of the 13 branches of this family is considered separately (considering those who reached the age of 40), one notes that branch 7 has an incidence rate for cancer of 18 per cent which is the rate expected in the general population. Branches 2 and 12 have rates of 11 and 10 per cent respectively, while all of the remaining branches have rates of 5 per cent or less which gives the overall rate of 4.2 per cent.

Breast cancer occurred in four individuals (among whom one survived two primary breast lesions and died at age 76 of a CVA). Basal cell carcinoma occurred in two patients as did bladder cancer. Bladder cancer occurred in persons who were known to be cigar smokers. Cancer of the esophagus occurred in a 56-year-old man who was known to have been a heavy drinker. The late age of cancer onset is noteworthy in four individuals (i.e., 77, 79, 71, and 84). One child developed a brain tumor at the age of six years and died at the age of nine years. The average age at death of 197 family members who died at any age was 52.2, but when only the 150 members who reached the age of 30 were considered, the average age at death was 65.1. Seven individuals are alive in their seventies and 14 in their eighties.

(2) Osteogenesis Imperfecta

Osteogenesis imperfecta (OI) is a multisystem collagen disease most noteworthy for bone involvement wherein fractures oc-

Figure 1

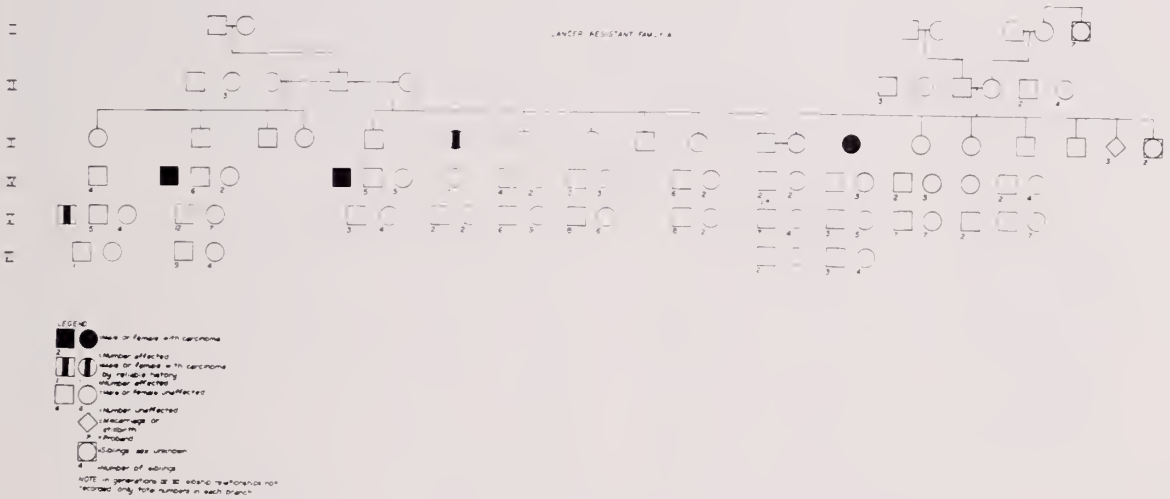

Table 1

FAMILY A
(Cancer-Resistant)

Branch of Family	Total No. (All Ages)	No. With Cancer (All Ages)	%	No. Members Over Age 40	No. with Cancer After Age 40	%	Multiple Primary Lesions
1	17	1	8%	5	--	--	--
2	62	1	2%	18	1	6%	--
3	19	1	5%	10	--	--	--
4	8	1	12%	8	1	12%	--
5	22	--	--	22	--	--	--
6	20	--	--	6	--	--	--
7	19	--	--	7	--	--	--
8	30	--	--	14	--	--	--
9	20	1	5%	11	1	9%	--
10	20	--	--	5	--	--	--
11	4	--	--	2	--	--	--
12	25	--	--	6	--	--	--

cur with only minimal trauma. The condition is inherited as an autosomal dominant with marked variable expressivity of the gene.[12]

We have reviewed the world literature on the subject through 1965 and found that cancer was reported infrequently in this disease.[13] These reports concern osteogenesis imperfecta tarda which in most instances does not impair normal expectations of longevity. Furthermore, the validity of the reports of malignancy in several of these studies is in question. The one instance reported by Bell[14] was based on a vague statement by Greenish[15] ". . . he is said to have died from cancer." The two cases suspected to be sarcoma found in families studied by Seedorff[12] were later proven to be normal on biopsy. The study by Werner[16] showing three cases of sarcoma associated with OI in members of a family did not contain histologic verifications. This point is exceedingly important in that the hyperplastic callous formation during healing at the fracture site in OI may simulate sarcoma in every detail only to be proven normal when a biopsy is obtained.[17-19] Finally, review of

Figure 2

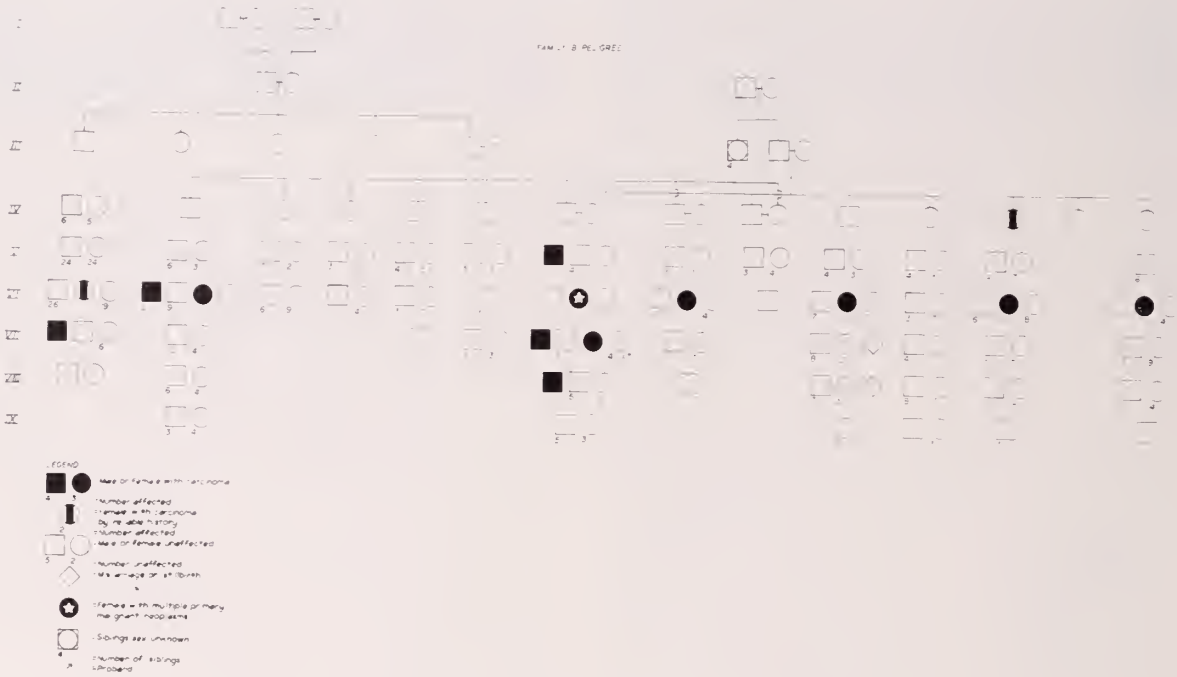

Table 2

FAMILY B
(Cancer-Resistant)

Branch of Family	Total No. (All Ages)	No. With Cancer (All Ages)	%	No. Members Over Age 40	No. with Cancer After Age 40	%	Multiple Primary Lesions
1	116	2	--	105	2	2%	--
2	68	3	4%	28	3	11%	--
3	25	--	--	22	--	--	--
4	12	--	--	10	--	--	--
5	17	--	--	12	--	--	--
6	18	--	--	14	--	--	--
7	53	5	9%	22	4	18%	1
8	42	1	2%	30	1	3%	--
9	10	--	--	6	--	--	--
10	57	1	2%	35	1	3%	--
11	56	--	--	23	--	--	--
12	64	3	5%	29	3	10%	--
13	51	1	2%	19	1	5%	--

the subject through 1965 has shown only one additional malignancy, namely that of Roschlau[18] showing sarcoma (histologically verified) in a patient with OI. However, this case must be evaluated from the standpoint of another disease which this patient had, namely the Rothmund syndrome, in addition to OI.

(3) Diabetes Mellitus

Diabetes and cancer have many interesting features in common, the most prominent of which is the fact that both are chronic diseases with a relatively late age of onset. Thus, their prevalence significantly outnumbers incidence. In many cases hereditary factors have been strongly invoked for these diseases although in each there are also many examples wherein environmental factors appear to be of critical importance in their etiology. In turn, each disease may be associated with a wide range of endocrinologic abnormalities including the well established aberrations in carbohydrate tolerance. Thus, with such common ground as this, it is not surprising that intense interest has been expressed in the possibility of meaningful associations between these two diseases.[20]

Limitations to the interpretation of data linking cancer to diabetes are: (1) the problem of whether diabetes in a cancer patient results from a diabetogenic action of the tumor and/or some type of hormonal imbalance related to the tumor; (2) whether diabetes mellitus per se is a disease either predisposing to cancer in certain patients or whether the presence of this disease protects or spares the patient from the development of cancer. To help resolve these issues scientifically so that meaningful data might be obtained would obviously be a major undertaking. Unfortunately, at the present time no data exists which can materially elucidate the problem. Practically all of the available information is retrospective.[20] The majority of studies fail to take into consideration the family history of cancer and/or of diabetes mellitus and in many cases the data fail to clearly illuminate the chronological relationship of these diseases. A prospective study of a large series of patients with diabetes mellitus is needed with careful medical evaluation of the diabetes history and laboratory findings with a well documented family history of diabetes, cancer, and other disorders. Finally, a matched control population, selected for the absence of diabetes mellitus, should be available. A study of this magnitude would obviously be expensive and would require a prolonged period of time; nevertheless it would undoubtedly be of merit in helping to settle the controversy about the association of diabetes mellitus and cancer.

An extensive review of the current literature has been provided by Kessler[20] covering several categories of the problem as follows: (1) clinical studies of carbohydrate metabolism in cancer patients; (2) laboratory studies of carboyhdrate metabolism of tumors; (3) studies of cancer and diabetes in autopsy populations; (4) studies of cancer risk among diabetics; and (5) miscellaneous studies.

This review uncovered a serious problem which influenced the majority of these works, namely, the fact that methods utilized in the study of patients and controls as well as the criteria for assessing diabetes differed widely. However, in spite of these shortcomings, when all studies were considered collectively, clinical evidence supported a positive association between cancer and a concomitant dysfunction in sugar metabolism. These studies were retrospective and a temporal relationship in this association could not be elucidated; nor could information be obtained concerning metabolic derangement, particularly with respect to whether it was characteristic of cancer or whether it was consistent with the presence of a chronic disease in general.

On the other hand, in contrast to the positive association between diabetes and cancer in the clinical studies, a negative association between cancer and diabetes was observed in the majority of the autopsy-based studies. However, methodologic problems in these studies, as in the clinical studies, impose limitations and warrant caution in their interpretation. For example, a bias may have been present in that cancer patients may have been preferentially selected for autopsy when compared with patients

dying from diabetes mellitus. Also, the number of autopsies may differ among certain ethnic, racial and socio-economic groups, and as a result a particular group may be more prone to diabetes, but less likely to have autopsies performed. While the autopsy data in general tended to show a decreased association with cancer, one noteworthy exception was found in pancreatic carcinoma, the prevalence of which was significantly increased among descendants of diabetic patients.

Kessler[21] evaluated cancer mortality among 21,447 diabetic patients who were seen at the Joslyn Clinic in Boston during a 26 year period ending in 1956. This analysis was made through the calculation of standardized mortality ratios wherein the observed numbers of deaths due to cancer were compared with those expected for age and sex specific ratios from the general Massachusetts population during the same period of time. Results showed that cancer mortality among the female diabetic patients was approximately that which was found in the general population of Massachusetts. However, in contrast to the females, the male diabetics showed a significantly reduced risk for death from cancer. This reduced cancer risk was even present when deaths from lung cancer were included. Kessler suggested that this reduced cancer risk among the diabetics was attributable to two factors, namely an excessive risk of deaths from other causes among the diabetics (excluding cancer), and an over representation of Jews among the diabetic patients. This study confirmed previous studies which indicated an increased risk of death from carcinoma of the pancreas among patients with diabetes mellitus. However, the explanation for this association is exceedingly complex and may involve possible carcinogenic potentialities of exogenous animal insulin influence. Finally, Kessler's data[21] provided evidence that diabetic females did not show an increased mortality from endometrial carcinoma. This observation is in contradistinction to several large retrospective studies of endometrial carcinoma patients.[22-24] Interestingly, diabetes mellitus has been shown to be negatively correlated with intracranial neoplasms.[25]

(4) Glucose-6-Phosphate Dehydrogenase (G-6-PD)

Glucose-6-phosphate dehydrogenase deficiency is inherited as a sex-linked factor. Beaconsfield *et al*[26] noted an inverse association between G-6-PD deficiency and cancer mortality. These observations were based primarily on comparisons between occidental and oriental Jews. Thus, these findings suggested that individuals with G-6-PD deficiency have a relatively decreased cancer risk when they are compared with non-deficient individuals.

Naik and Anderson[27] found a lower frequency of G-6-PD deficiency in both male and female American Negroes with cancer when compared with controls.

Kessler[28] suggested a similar inverse association between diabetes and cancer, based in part, upon the positive association between diabetes mellitus and G-6-PD deficiency.

The associations between G-6-PD deficiency, cancer, and diabetes mellitus merit further study. It also suggests the importance of searching for additional biochemical factors in studies of cancer prone as well as cancer resistant genotypes.

It has been suggested that an hereditary deficiency of G-6-PD may inhibit the hexosemonophosphate (HMP) glycolytic pathway and thus diminish the risk of developing cancer.[26] The relatively high incidence of G-6-PD deficiency among Oriental Israeli males[29] and the low cancer death rates reported for this group[30] may be correlated through this mechanism. And, in view of the heightened proclivity of Jews to the development of diabetes,[31] it may be of some significance that the HMP shunt is stimulated by insulin and depressed in diabetes mellitus.

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Gas Infections: More Than a Textbook Entity*

PART I

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and
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ABSTRACT

"Gas gangrene" is an inexact term describing only a portion of the spectrum of anaerobic wound infections. Classically, "gas gangrene" refers to the fulminating myonecrotic infection caused by the clostridia group of microorganisms. However, other anaerobic bacteria can mimic this process, and early differentiation of these infections on a clinical basis may be difficult.

We have recently seen a number of patients with "gas gangrene." The severity of this disease ranged from a mild to a rapidly progressive and devastating process of clostridial myonecrosis. These infections have been related to trauma, operations, a neglected ischiorectal abscess, ischemic peripheral vascular disease, and drug addiction.

These patients have been managed with conservative and aggressive operative procedures, massive doses of antibiotics, hyperbaric oxygen treatments, and intensive supportive care.

The role of hyperbaric oxygen therapy and the polyvalent "gas gangrene" antitoxin in treatment of severe anaerobic infections, have not been clearly defined. We have utilized an integrated diagnostic and therapeutic program successfully.

Case summaries emphasizing the spectrum of anaerobic infections and the principles of surgical management are presented.

Introduction

THE specter of "gas gangrene" continues to loom over our operating suites, emergency rooms, and hospital corridors. "Gas gangrene" (clostridial myonecrosis) is one of the most rapidly advancing and lethal diseases known to man. Physicians seldom consider gas-forming anaerobic infections as a potential or real complication of elective operations. These infections are rarely diagnosed *early* because the *initial* wound signs are not incriminated as the cause of subtle elevations in temperature and pulse. Most surgeons would consider clostridial infection as one of the possible results of accidental trauma but may not appreciate its importance in the patient already in the hospital. In fact, it seems to be more virulent in the latter group as noted in one recent series of 29 patients. Of all the etiological causes, mortality was greatest for patients in whom "gas gangrene" was a complication of abdominal operations.[1] This was also true in our own cases.

The anaerobic microorganisms are ubiquitous and conditions favoring their growth are common. It is remarkable we do not see "gas gangrene" more often than we do.

Historically, as is so often the case, Hipprocates[2] was first to describe this condition. In the fifth century B.C. he wrote, "Criton of Thasa commenced to experience pain in his foot . . . He had a slight chill, some nausea, and then a little fever; he became delirious during the night. On the second day there was swelling of the entire foot and over the whole ankle, which was a little red and tender; there were present tiny black blebs and he had a great fever. The sick one was completely out of his head and there were frequent evacuations of bilious matter. He died the second day."

Case Reports

Table 1 summarizes the pertinent history

*Presented at the Nebraska Chapter of the American College of Surgeons Meeting, October 14, 1971, Lincoln, Nebraska.

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and physical findings at the time of admission to University of Nebraska Hospital. Most of these patients were referred to us after intial treatment did not seem to arrest the progress of the infection.

Three cases followed operative procedures: cholecystectomy, lower extremity amputation, and sigmoid colon resection. One was related to the self-administration of intramuscular drugs; one was secondary to a neglected ischiorectal abscess; and only one case out of seven was directly related to trauma.

Both deaths occurred in the patients who developed gas infections following abdominal operations.

Case One. A 65 year old man with a six year history of sigmoid diverticulitis entered the University of Nebraska Hospital with an acute episode. This responded to bowel rest, intravenous fluids, and antibiotics. Eight days after admission, and following mechanical and oral kanamycin sulfate bowel preparation, sigmoid resection with end-to-end anastomosis and transverse colostomy were carried out. No free pus was encountered, and no soiling of the peritoneal cavity occurred.

Eighteen hours following operation he developed fever, tachycardia, and premature ventricular contractions. Frequent examinations of the patient and laboratory studies did not reveal the etiology of this toxemia. The wound was incriminated at 48 hours at which time erythema, foul-smelling serosanguineous drainage, and radiographic evidence of subcutaneous gas were present. Culture showed Clostridia, Bacteroides, and anaerobic Streptococci.

Cephalothin and kanamycin sulfate were given since the patient was allergic to penicillin. The gangrenous anterior abdominal wall was resected and the resulting defect was covered with Dacron mesh.

SUMMARY OF FINDINGS IN PATIENTS WITH ANAEROBIC INFECTIONS

TABLE -1-

Age	65	6	60	67	30	60
Sex	M	M	M	M	F	F
Site	Abdominal wall	Groin	Perineum	Abdominal wall	Upper arm	Leg
"Etiology"	Bowel resection	Farmyard laceration	Ischiorectal abscess	Cholecyst-ectomy	I.M. drugs	Aorto-iliac occlusive disease
Past medical history	Divertic-ulitis	0	0	Diabetes mellitus	Systemic lupus ery-thematosis	Diabetes mellitus
Incubation period	18 to 24 hrs.	18 hrs.	?	18 to 24 hrs.	?	24 hrs.
Tissue gas	+	+	+	+	+	-
Temperature (°C)	39°C	38.5	37.2	38.5	37.5	39°
Pulse	130	90	100	108	88	100
Blood pressure	130/85	110/70	140/70	98/70	130/80	160/90
Hemoglobin (grams%)	16.2	12.3	12.4	9.7	10.6	9.7
Plasma Hemoglobin (mg%)	10.0	4.0	17.0	675.0	Not.done	Not.done
WBC	19,300	38,200	15,500	Not done	25,300	19,600
BUN (mg%)	30	9	28	105	13	10
Culture wound	Clostridia Bacteroides Streptococci	Clostridia	Bacteroides Clostridia Streptococci	Clostridia	Streptococci	Clostridia Bacteroides Streptococci
Hyperbaric oxygen therapy	+	+	+	+	0	0
Final outcome	Died 8th Post-op day	Alive	Alive	Died 3rd Post-op day	Alive	Alive
Type of infection	Clostridial myonecrosis	Anaerobic cellulitis	Clostridial myonecrosis	Clostridial myonecrosis	Streptococcal myositis	Anaerobic cellulitis

Four hyperbaric oxygen treatments (100% oxygen at three atmospheres) were employed. The debrided wound remained clinically clean and the degree of toxemia decreased over the next 48 hours until secondary invasion by Pseudomonas aeruginosa developed. Toxemia again returned and the patient had an acute upper gastrointestinal hemorrhage secondary to diffuse hemorrhagic gastritis. He deteriorated rapidly following these combined insults and died on the eighth postoperative day.

At the time of his death only Pseudomonas aeruginosa was cultured from the wound and blood.

Comment

Anaerobic bacteria far outnumber aerobic bacteria in the intestinal tract. Kanamycin-Neomycin "bowel preps" have little effect upon the anaerobic organisms, including Clostridia, and in fact may allow their overgrowth.[3-6] The systemic signs of anaerobic infections can occur as early as six hours after contamination. If the obvious causes of fever and tachycardia in the immediately postoperative patient are not found, careful examination of the incision is indicated.

Case Two. A 67 year old diabetic man had a cholecystectomy and common duct exploration for obstructive jaundice secondary to choledocholithiasis. A right subcostal incision was employed. No unusual operative problems were encountered but the patient began to complain of increased incisional pain approximately 24 hours postoperatively. Fever and tachycardia were also present. By 48 hours, an obvious wound infection with marked surrounding skin discoloration, edema, foul serous discharge, and subcutaneous gas were present. He was referred to University of Nebraska Hospital and was moribund on arrival. On examination crepitation extended well up onto the chest wall from the infected wound. Laboratory evidence of anemia and hemolysis were also present.

The patient had cardiopulmonary arrest in the emergency room, was resuscitated, and transferred to the hyperbaric oxygen chamber. He died during the initial treatment. Wound culture showed Clostridia.

Comment

We believe this case represents fulminant clostridial myonecrosis with severe systemic toxicity, including hemolysis. The diabetic patient seems to be especially at risk for this and other anaerobic infections. The source of the bacteria in this case was undoubtedly the gallbladder.

Case Three. A six year old boy was playing in the farmyard when he fell against a piece of farm equipment and sustained a deep laceration in the right groin. The great vessels were not involved and the wound was cleaned and sutured primarily. Approximately 18 hours later, there was increased pain at the site of injury as well as serosanguineous drainage. The sutures were removed, and the patient was transferred to the care of a surgeon, who made an early diagnosis of a gas forming infection. Culture showed Clostridium perfringens. By this time the process involved the upper leg, groin, and scrotal areas. The sites were surgically explored and debrided and fasciotomies were performed. The boy was transferred to University of Nebraska Hospital for hyperbaric oxygen therapy and continued care. On arrival there, the infectious process was already well under control. The wound was clean, and the patient showed no signs of toxemia. The remainder of his treatment consisted of continued antibiotics, daily dressing changes in the operating room, and eventual split thickness skin grafting.

Comment

This case probably represents anaerobic cellulitis. The fact that muscle per se was not involved differentiates this infection from clostridial myonecrosis. This diagnosis is also supported by the low degree of systemic toxicity. Effective treatment here consisted of intravenous penicillin, opera-

tive debridement, and supportive care. Hyperbaric oxygen therapy was not necessary because of the successful results of adequate surgical debridement.

Case Four. This patient was a 30 year old woman with a past history of systemic lupus erythematosis for which she had been taking cortico steroids several years. She was a frequent user of self-administered intramuscular narcotics.

She presented to University of Nebraska Hospital with a three day history of pain, swelling, and discoloration of the right upper arm. X-rays showed soft-tissue gas in the area of the deltoid muscles. Operative debridement of the necrotic muscle was carried out. Cultures showed anaerobic Streptococci.

Hyperbaric oxygen was not employed, and toxemia was never severe. Split thickness skin grafting was used to cover the involved area. She returned to her environment only to be readmitted 45 days later with the identical problem in the opposite arm. A similar treatment program was again successful.

Comment

This is a case of another anaerobic gas-forming infection, streptococcal myositis. Gas-forming infections are a distinct hazard of drug addicts.[5] The additional problems of systemic lupus erythematosis and steroid therapy certainly place this patient in the "at risk" group for anaerobic infections.

Nebraska Birth Defects Prevention Program

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THE Nebraska Department of Health, in July, 1972, began a new program to implement and develop scientific investigations and research concerning the causes, methods of prevention, treatment, and cure of birth defects. The 82nd Legislature of Nebraska, in passing Legislative Bill 1203, recognized that "The occurrence of malformation or inherited disease at the time of birth is a tragedy for the child, the family, and the community, and a matter of vital concern to the public health."

In attacking this problem, the Department of Health has implemented the following program activities: (1) research, (2) genetic counseling, (3) prenatal detection, (4) a birth defects registry, (5) professional education, and (6) public health education. Many of these activities are carried out at the Human Genetics Laboratory at the University of Nebraska Medical Center. James D. Eisen, Ph.D., Director of the Medical Center's Genetic and Birth Defects Program, has been extensively involved in research, genetic counseling, prenatal detection, and professional education. Dr. Eisen, in cooperation with the Department of Health, has made significant progress informing physicians about the program. He has addressed several county medical societies as well as other professional groups and seminars. This effort to inform Nebraska physicians of the services available through the program will continue. Professional groups are encouraged to contact the Health Department to arrange for a presentation by Dr. Eisen concerning the program and recent advances in human genetics.

Another significant area where considerable activity has transpired is the Birth Defects Registry. Legislative Bill 1203 indicates that "Birth defects and allied diseases shall be reported by physicians, hospitals, and persons in attendance at births in the manner and on such forms as may be prescribed by the Department of Health." In addition to the information obtained from birth certificates, a hospital reporting system was initiated to provide more complete information. A recent study indicates that only 22 percent of the major and minor malformations are reported on birth certificates.[1] The hospital reporting system, which was recently activated in 106 Nebraska hospitals, is designed to increase effective reporting significantly. The reports are to include all congenital malformations diagnosed up to one year of age. An individual in each hospital has been designated as the source of the required reports.

The coded data obtained from the reports is submitted to the Congenital Malformations Surveillance Program at the Center for Disease Control for computer interpretation and surveillance. Patient, hospital, and physician confidentiality are maintained by the Department of Health. A bimonthly report[2] is published by the Center for Disease Control listing comparative congenital malformation data from Nebraska and other geographic areas. Individuals wishing to receive this report should contact the Health Department's Birth Defects Program.

The need for more complete reporting of congenital malformations has become very apparent. The Department of Health urges all physicians in Nebraska to make specific note of such malformations and bring the notation to the attention of their hospital's medical record librarian. The Birth Defects Prevention Program, like so many other Health Department programs, is vitally dependent upon the active support of the Nebraska physician.

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Emergency Transportation of the Neonate*

PART I

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A workshop meeting was held in Lincoln, Nebraska on May 23, 1973, sponsored by the State Department of Health, the Nebraska Chapter of the American Academy of Pediatrics, Creighton University School of Medicine, and the Department of Pediatrics of the University of Nebraska School of Medicine to discuss the problems encountered in providing an up-to-date system of transport for the high risk infant. Included among the speakers was Dr. Alfred W. Brann Jr., Assistant Professor of Pediatrics and director of Newborn Center at the University of Mississippi School of Medicine, Jackson, Mississippi. The proceedings of the meeting are summarized, and recommendations are made for expanding the transportation facilities available for the high risk infant and for stimulating physicians in Nebraska and surrounding areas to increase their awareness of the need for early detection of potential prenatal disasters and to consider early transportation of the high risk mother as well as the infant.

The story of emergency transportation for the harassed infant is not a new one in the state of Nebraska. As early as 1938, Dr. Loder of the State Health Department designed a device for transporting premature infants. This was a plywood box equipped with windows, a heating device, and an inlet for oxygen. The instructions stated that it was essential to locate a source of oxygen to accompany the infant, and that this might most frequently be obtained from the local fire department. While the physical facilities for transporting infants have improved in recent years, the organization of a statewide network for providing uniformly good transportation for high risk infants is not available at the present time. Although this represents a significant void in the health care delivery system in the state of Nebraska and surrounding areas at this time, there must be further development and organization in several aspects.

Dr. Robert Grant presented the perinatal statistics for the year 1971 in the state of Nebraska. It was noted that approximately 99% of births in the state of Nebraska occurred in hospitals, yet 75% of the 102 hospitals with maternity services delivered fewer than 200 deliveries a year, 50% had fewer than 100 deliveries a year, and 25% had fewer than 50 deliveries a year. These hospitals are obviously unable to provide intensive care for high risk infants, and become a prime source of concern in providing emergency transportation for problem infants delivered in smaller obstetrical units in the state. Although the 1971 figure of 14 neonatal deaths (less than 28 days) per 1,000 live births is less than the national average, this can further be reduced to a reasonable estimate of 8 deaths per 1,000 births. Adequate statistics are not available for the even more important part of the perinatal problem — the morbidity of residual physical or intellectual impairments that result from prenatal events which could be prevented or minimized by the availability of an improved system of neonatal intensive care units and a rapid, efficient, and safe system of transportation of high risk infants from source of delivery to a regional newborn intensive care unit.

At the present time, there are five neonatal intensive care centers in the state of Nebraska — The University of Nebraska Hospital, Creighton Memorial - St. Joseph's Hospital, Archbishop Bergan Mercy Hospital in Omaha; St. Elizabeth's Hospital in Lincoln; and St. Mary's Hospital in Scottsbluff. There are six trained neonatologists in the state of Nebraska, Drs. Bolam, Miyazaki, Van Leeuwen at the University of Nebraska Medical Center, and Drs. Arango,

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Meyers, and Shepard at the Creighton University Medical Center and the affiliated program at Archbishop Bergan Mercy Hospital. The establishment of regional intensive care facilities for neonates at several strategic locations in the state is being studied by Dr. Grant, the State Health Department, and others. The development of a system for referral to either a regional center or to a university center for high risk care is an important part of the establishment of organized system of both intensive care of the neonate and emergency transportation of these infants.

Problems Encountered in Emergency Transportation of the Neonate

Clearly, the ideal solution to the emergency transportation of high risk infant would be to have the high risk mother delivered at a center equipped with a neonatal intensive care unit. Unfortunately, even under the best of circumstances, at least one third of the neonatal complications cannot be predicted antenatally or during labor. The problems associated with transporting infants might be therefore minimized by referral of high risk mothers to regional centers, but inevitably, the need for transporting the unexpected sick infant will remain a major problem. The problems to be encountered include not only those problems peculiar to the pathophysiology of neonate, but also geographic, social, and economic problems.

Special Problems of the Neonate

While the newborn requires considerably less space, can be handled by one or two persons in transport, and rarely needs to be picked up in remote areas away from a source of medical supplies, there are many problems that are peculiar to the newborn that require special consideration during the transportation.

Temperature Regulation. A pressing concern for the neonate is the need to provide a well controlled source of external heat for the infant to prevent the development of severe hypothermia. The newborn, contrary to the statements in older literature, is not a poikilothermic animal — that is, his oxygen needs do not decline as environmental temperature is lowered. Like the adult, his oxygen consumption increases significantly as his environmental temperature declines. Unfortunately, unlike the adult, the newborn, particularly the premature, is poorly equipped to meet the demands placed on him for heat generation. The newborn has a very large surface area per unit of body weight in comparison to the adult. A figure of 2.5 times the radiating surface per unit of body weight is often quoted for the small infant in comparison to the adult. This means that the small infant is far more likely to lose heat from radiant heat loss under given conditions than in proportion to his ability to generate heat. The sources of heat loss — radiation, evaporation, and convection, all play a role in the neonate, and these factors are even more exaggerated in the sick neonate, who has frequently required prolonged periods of exposure to cool environments for resuscitative procedures in the delivery room, investigative studies in the radiology department, or therapeutic maneuvers such as intubation and catheterization of umbilical vessels. It is not uncommon to find small infants transported to referral centers with body temperatures of 92° to 94° F recorded at the time of their admission. Not only is hypothermia of this magnitude associated with a high mortality rate, but it also leads to further exaggeration of the problems of metabolic acidosis and of hypoxia at the cellular level frequently encountered in the ill newborn.

Problems of Oxygen Delivery. The immature infant is particularly vulnerable to the two extremes of oxygenation — central nervous system and cardiovascular effect of hypoxia on one extreme and the devastating effects of retrolental fibroplasia produced by hyperoxygenation at the other. The ability to maintain adequate levels of oxygen concentration in the arterial blood must be an overwhelming concern of every physician involved in the care and transport of high risk infants. The availability of a system which provides the ability to monitor closely the concentration of oxygen being delivered to the infant during transport is essential. At the present time only the crudest methodology is available; that of observation of the infant or his blood for appearance of adequate oxygenation and maintenance of

inspired oxygen at lowest possible level to alleviate cyanosis are utilized.

Two other aspects of oygen delivery to the infant during transport are of importance. The first of these centers around the effect of changing altitudes on oxygen concentrations and on the volume of gas in confined spaces. The infant with significant respiratory or cardiopulmonary problems should obviously be provided with supplemental oxygen if air transport in unpressurized planes is to be utilized for altitudes above 5,000 feet. The linear decline in the oxygen tension of inspired air as altitude increases is a well recognized fact, but the impact of this in a small infant is often not taken into consideration. The other factor related to increasing altitude which occasionally presents a problem is the effect of the expansion of gas in a confined space as atmospheric pressure is lowered with increasing altitudes. Due consideration should be given to this in selecting air transportation for infants with either pneumothorax or with intestinal obstruction with localized accumulations of gas within body cavities. The expansion of the confined volumes of gaseous atmospheric pressure may result in significant worsening of the infant's condition during transport.

The other major aspect of oxygen delivery to the infant relates to the need to provide mechanical ventilation for infants during prolonged periods of transport. While short-term mechanical ventilation is easily carried out during transport by utilization of an infant anesthesia bag and mask or an infant resuscitator, such as HOPE or Ambu bags, maintenance of optimal mechanical ventilation for longer periods of time would be best carried out by the use of a positive pressure respirator during transport. Several units are available to meet these needs, but their utilization requires the availability of skilled personnel for management of the respirator and for maintenance of clear airway during transport. The impact of this on the transport facility is significant — space requirements for adequate supply of oxygen and for the location of the respirator in the transport vehicle, as well as the availability of a source of power for those respirators that require electric current are factors to be considered.

Fluid Administration and Correction of Acidosis. Two major biochemical derangements frequently encountered during high risk infants that demand immediate correction prior to and during transportation are metabolic acidosis and hypoglycemia. The documentation of arterialized capillary blood pH and PCO_2 are extremely important in the accurate assessment of the extent of acidosis in the sick neonate. Many community hospitals possess capabilities for determination of pH and PCO_2, and these should be utilized whenever possible. When such laboratory facilities are not available, arbitrary clinical decisions are often made on the assumption that any neonate with idiopathic respiratory distress syndrome or with asphyxia is significantly acidotic. However, to avoid overcorrection of acidosis, pediatricians often deliberately underestimate the amount of sodium bicarbonate or THAM to be given to infants if pH values are not available, resulting in suboptimal treatment during the period of transport.

Significant hypoglycemia is also frequently encountered in the high risk neonates; the infant with intrauterine malnutrition who develops hypoglycemia because of inadequate hepatic stores of glycogen; the infant of a diabetic mother who develops hypoglycemia because of excessive pancreatic insulin production; and the profoundly stressed infant who has utilized his available stores of glycogen during periods of hypoxia; all require prompt recognition of hypoglycemia and prompt institution of intravenous glucose therapy. While rough evaluation of blood sugar levels can be made utilizing Dextrostix, even during periods of transport of the infant, the availability of facilities for instituting and maintaining intravenous fluid administration for both the acidotic and hypoglycemic infant becomes extremely important. The transport facilities must include adequate space for I.V. fluids and under optimal circumstances should also be equipped with a continuous pump for the administration of these fluids either through umbilical venous or arterial catheters.

SPECIAL ARTICLE

From a Fifty Year Pin Wearer

CLARENCE F. BANTIN, M.D.

NOTHING earlier than 1922 has been included in this outline. In 1922 I received my B.Sc. degree from the University of Nebraska and in 1924 I received my M.D. degree from the University of Nebraska College of Medicine.

In 1924 I was given my Alpha Omega Alpha membership.

1924-1925 I interned at the University Hospital, Omaha. At this time the University plant consisted of the North and South lab buildings, and the East front unit of the hospital.

I relieved a retiring staff man of his pediatric clinic, ward walks, lectures, etc., at the University as well as an infant welfare station for the Visiting Nurses at 20th and Lake St.

The members of the Pediatric Department rotated responsibility for the care of the children at the Child Saving Institute.

The Benson Women's Club asked me to help organize a pre-school clinic in conjunction with the Visiting Nurses in August 1927. This was done and with the exception of the time I was in the Army I conducted the clinic weekly from August 1927 to 1955. By that time incomes had increased in the area we served until there were not enough families left who could meet the financial requirements for attendance, and the clinic was closed.

In 1929 I was appointed local surgeon for the Union Pacific R.R. For a number of years I was in charge of the X-ray Department. I retired from the R.R. in 1965.

In 1936 I served as President of the University of Omaha Extension Council.

In 1937 I was President of the Professional Men's Study Club.

1938-1967 I was an active member of the Children's Hospital Staff retiring as Associate Emeritus. October 26, 1973 I received a Certificate of Appreciation from the Trustees of the Hospital.

In 1940 I married Miss Angeline Phillips, who was Director of Nutrition at the University of Nebraska Hospital.

1926-1965 active member of the Immanuel Hospital Staff, President 1942 and 1943. Retired 1965. On November 18, 1968 I received a plaque for twenty-five years service.

1955 as Chairman of the Education and Preventive Medicine for the County Medical Society I organized and supervised the administration of the first polio shots. 122 doctors gave the immunizations at 104 schools to 16,824 children. I know of no reactions.

In 1948 I invited Dr. Paul Reed and about a dozen other general practitioners to my home one evening to see whether they would be interested in establishing a Nebraska Chapter of the American Academy of General Practice (now of Family Practice). They were, and as the years have gone by the original enthusiasm has continued, the Academy has grown in importance, and I expect it to continue.

I have received Life memberships in the American Medical Association, the Nebraska State Medical Society, the Omaha-Douglas County Medical Society and the American Academy of Family Practice (also Charter Member).

1943 to 1946 served in the Medical Corps of the Army at the William Beaumont General Hospital, El Paso, Texas. Rank Major.

Publications were:

Bantin, CF: Diabetic Lipemia Retinales and Fat Embolism, Report of a Case. JAMA 86:546-548, February 20, 1926.

Anderson HE, Bantin CF, Giffin HR, Ol-

son LJ and Schack CB: Primary Carcinoma of the Fallopian Tube. Obstet Gynecol 3:87-92, January 1954.

Hobbies are: piano, photography, drawing, collecting Meissen figures, play-writing. Won first place in a Press Club contest for best one act play. Later this play was run on the Orpheum Circuit. Title, "Memory Rose" 1926. "Parole" won first place 1928 for best one-act play in contest sponsored by the Drama League of America. Copperwork: Bas relief plaques. Exhibited at American Physicians Art Association Show, 1948 and 1949. Four pieces were exhibited. They were awarded two silver loving cups, and two silver medals.

President's Page

AMPAC - NebPAC
An Instrument for Increasing Professional Effectiveness

As a physician treating patients, you have spent your entire professional life witnessing a parade of improvements in medicines and over-all equipment and techniques which have enabled you to do a better job. We have all enjoyed the benefits of this progress, whether it be as patient or as physician. The quality of medical care has improved and we as physicians can take pride in our accomplishments.

AMPAC-NebPAC is an available instrument which we have not used to full capacity. AMPAC-NebPAC, our political action organizations, can help us immensely if we can overcome our political inertia and apathy to the extent necessary to use them.

We as physicians must recognize that as individuals and as a nation we are moving with steady consistency toward a regulated society. All other segments of our society (energy, banking, insurance, education, etc.) see this for themselves just as we do with PSRO and its predecessors. This progression toward regulation I believe is inevitable! The U. S. Congress faces over 19,000 bills annually, 10% of which have some relationship with medicine and health. Our own State Legislature annually faces an abundance of items of proposed health legislation influencing medicine. Many of these bills, both in the State Legislature and in the U. S. Congress, have a direct bearing upon our professional lives and the opportunity to practice quality medicine.

If we are to favorably influence this onslaught (disease!) we must make use of the only known consistant remedy — election of officials known to be of our own philosophy. Gentle democratic persuasion of officials of contrary convictions is an exercise in futility!

Such proposed legislation as HR 12053—National Health Policy and Health Development Act — already introduced in Congress is much more restrictive and regulatory than PSRO with which you are familiar. This bill is of no immediate threat to our way of life because it surely cannot be enacted at this time, but time and the regulatory progression seem inexorable. Who among you can doubt it?

Your active participation by joining AMPAC-NebPAC puts into your hands a tool for increasing your effectiveness as a physician — a tool to prevent and treat a disease — bad laws and bad regulations. We must elect public officials whose personal convictions are known to parallel those of us who are interested in quality unfettered medical care.

Dr. J. Dunlap

The Specialist

THE PROCTOLOGIST

Pity the poor proctologist. He is the butt of so many puns, and this is one of them, and my very own. Butt I am glad that we have him, for the last time I counted, we had more than a hundred different kinds of specialties, and we are getting more every day. This fellow gets to the bottom of our troubles (there I go again), and sooner or later, many of us may come to require his services, because what he treats is fundamental (oops); it is important and it can be very troublesome (I nearly said something about the seat of our troubles).

Everybody used to be a physician and surgeon, and then we got split into physicians and surgeons; then the physicians resplit and so did the surgeons, and the splintering will never stop. Butt the proctologist is safe, I think; there just isn't room for a subspecialty in his field.

We pay a great deal of attention to the upper part of our bodies, but too little to what's below. We are beginning to change this, but not the whole lower half, only in some quarters. I think that as time goes by, the proctologist will become more important to us, for we do get into trouble with what he works on, and even when we do not have anything very acute or very serious there, we do have a daily struggle to keep things all right, if you know what I mean.

I omitted some puns, like low man and end of our difficulties, because I do respect the proctologist, and when you need him, you won't think it's funny. He's a good man to have around.

—F.C.

Between Cases

Statistics.

The latest figures for first-year U.S. medical school enrollments, for this and last year, show 14,124 students in 114 schools.

Four years ago, there were 10,422 men and women, in 101 schools.

The percentage of women rose from 9.1 to 19.7 in these four years.

The Report.

There are tortuous varicosities extending down the medial side of the leg for a distance of 10 miles.

The Laboratory.

A culture was sent to 33 laboratories, not in this country; and 11 reported it as sensitive to penicillin, 19 as resistant, and 3 as doubtful.

Now You Know.

The celiac plexus is called the solar plexus because of its radiating nerves.

Quote Unquote.

Death neither wish, nor fear to see.

Martial.

Well?

RD publishes things like "I am Joe's Brain" and "I am Joe's Spine," and so on up and down the human-body line.

I'm waiting.

This Got Past The Steno.

Portable fibrosis.

Notes On The Difficulty Of Housebreaking Pets.

Turtles are deaf.

The Physical.

Reflexes are normal. However, the left knee jerk is hypoactive.

I Don't Believe It.

Two views of the left leg reveal again the post bone graft status of the fractures of the tibia and ulna.

Quote Unquote.

There is no love sincerer than the love of food.

Shaw.

Words We Can Do Without.

En bloc, parallel parking (they're all parallel), mitigate and militate, scion, forensic, addendum.

From The GU Department.

Ruinary bladder obstruction.
I understand.

That's What It Means.

Tibia: a pipe, flute.
Pelvis: a trough.

Department Of Dolorology.

He has never had any symptoms of rest pain.

O Very.

Because of the very normal intraocular pressure.

Lung Section.

Stop the bus, I'm dying of breath.

Dylan Thomas.

Down Memory Lane

1. Of the group of gunshot wounds of the chest in the World War, much was wreckage.

2. I think we have too generally accepted the idea that gall stones in themselves are harmless things. They are not. They are continually stirring up trouble, and appear to have a definite life history.

3. In twenty years the number of medical schools has been reduced from 180 to 60 and the number of medical students in attendance from 28,000 to 17,000. Moreover, the medical students of today spend more years in training, so that the decrease in graduates is even more marked than the decrease of students, only 2,529 getting diplomas in 1922 as against 5,742 in 1904.

4. Trudeau noted an abatement of his own symptoms when he refrained from bodily activity. He fished lazily from a boat on the days when he had fever.

5. The universal use of the blood pressure apparatus in life insurance examinations has contributed more to stimulate the layman's interest in his health than any other medical procedure.

6. The summer of 1923 brought a revival of interest in Ethylene which is hailed as a new anesthetic.

7. An increasing number of Nebraska physicians are taking advanced postgraduate courses, which augurs well for the future of the profession.

8. In the three years preceding the introduction of insulin the mortality from diabetes among industrial workers had increased 28%; in 1923 the mortality decreased 6.4%. This tells the story of insulin briefly and forcibly.

9. The injured is only authorized to select his own physician in case of major operation.

10. Royal and Brunswick, Nebr., are reported without physicians.

Nebraska State Medical Journal
May, 1924

Presidential Page

A President, at the completion of his term, often recounts his accomplishments, and sometimes, even the shortcomings of his administration. I shall forego that opportunity for the record pretty well speaks for itself, and I have long since learned that it is unnecessary to explain yourself to your friends and there is no object in doing so for those who are not. I would prefer to discuss a few philosophical matters as they relate to the NMA and to share with you my impressions as seen from the standpoint as President of the Nebraska Medical Association.

During my remarks at Kearney a year ago at my Inauguration, I spoke of the challenges that faced Nebraska medicine. I should like to report to you that we have met all these challenges and that they were solved. This is not the case, but many of these challenges have provided considerable thought and study.

Without doubt, we have spent more time and effort trying to understand the new PSRO and to decide what our posture will be in that regard. At the present time, we are in compliance with the law, have requested and received a single, state-wide PSRO designation; and have a Committee working to form a model PSRO which the membership can consider. At the same time, we are exploring the possibility and propriety of repeal of this unsatisfactory law. We have objected to the Cost of Living Council Regulation regarding Phase IV in the continuance of the health providers under price control. The AMA has finally brought suit against the Cost of Living Council in this regard and we hope for an early resolution.

We have instituted a Health Planning Committee of the Nebraska Medical Association which is the first time for this type of effort. After wrestling with the Nebraska Health Project a year ago, it became quite evident that we must embark on some type of effective health planning for the state.

We have made a conscious effort to promote the Nebraska Medical Association and the American Medical Association's memberships. I have had the opportunity as President to visit several of the larger component Societies and I was interested in what seemed to be renewed interest in membership in state and national organized medicine. I have the impression that as practicing physicians increasingly feel the yoke of Governmental regulation, there will be a return to the fold of organized medicine.

It has been a pleasure to serve as President of the Nebraska Medical Association. It has been a matter of great personal satisfaction to be associated with this organization, and to make good friends among its leadership. I shall continue to serve, in whatever manner, for the continuance and prosperity of the organization.

John D. Coe, M.D.

Our Medical Schools

TV award

Creighton University and Saint Joseph Hospital have received the 16th annual Television Award presented for outstanding service to the public through KMTV.

The award was presented at a dinner at the Omaha Hilton Hotel attended by 160 Omaha area civic, business and government leaders.

The award recognized a series of four prime time programs on KMTV about health topics of wide-ranging interest.

The programs, produced by Creighton University and Saint Joseph Hospital and presented by Physicians Mutual Insurance Company, covered pregnancy and fetal monitoring, trauma, the financing of health care, and dental education.

Creighton grant

Creighton University has received a $3,000 gift from the General Mills Foundation. The money is to be used for the educational development of minority students in Creighton four health science schools according to Reverend William F. Kelley, S.J., Creighton's Director of Government Relations and Special Resources.

Father Kelley said the General Mills Foundation has agreed to contribute similar amounts in 1975 and 1976 subject to evaluation of Creighton utilization of the funds.

Dr. Dial

"Dr. Dial," a telephone health information service available at no cost to residents of the metropolitan Omaha-Council Bluffs area, recently marked its second anniversary.

Bryce Brasel, the voice of "Dr. Dial" and Director of Creighton's Health Sciences Information Bureau, said more than 700,000 calls have been placed to "Dr. Dial" in the past two years. Calls now average approximately 600 per day. Persons calling "Dr. Dial" hear a pre-recorded health message of general interest. The service is provided jointly by Creighton University's Criss Institute for Health and Saint Joseph Hospital.

Pediatrics program

Joseph M. Holthaus, M.D., Dean of Creighton University's School of Medicine and Creighton's Department of Pediatrics, recently announced the implementation of a Community Pediatrics Program.

The program seeks to join medicine with other professions and organizations in an effort to improve the quality of life for all children. Dr. Shepard has appointed Matilda McIntire, M.D., as Director of the Community Pediatrics Division. Creighton requires four months of community pediatrics training for all residents in the pediatric program.

Dr. Eliot named

Dr. Robert S. Eliot, professor of internal medicine and director of the cardiovascular center at the University of Nebraska Medical Center, has been named a regional coordinator for the National Committee for Continuing Education Programs of the American College of Cardiology.

He will coordinate the Mountain Region, which consists of Montana, Wyoming, Idaho, Utah, Colorado, New Mexico, Arizona, Kansas, and Nebraska.

Creighton: family practice

Creighton University's Division of Family Practice has opened a new health center in Northeast Omaha. Two physicians who had been serving the area retired from private practice. Dr. Paul Reichstadt joined the Creighton Medical School faculty and Dr. William Kemp joined the emergency staff at Lutheran Medical Center.

Dr. Michael Haller, Chairman of Creighton's Department of Family Practice, said

types for Tylenol®
(acetaminophen)

patient with
ma or allergy

The patient with gastritis

The patient on uricosurics

The patient on anticoagulants

The peptic ulcer patient

The febrile, dehydrated child

Since there are so many, why not use TYLENOL® tablets and elixir routinely for pain or fever?

When one of the types
patients pictured above needs
analgesic,
have another 'type for
LENOL (acetaminophen)'—
erson who should avoid aspirin.
Considering their number,
uldn't it make sense—and
vide an added margin of safety
o recommend TYLENOL
etaminophen) to all the
patients in your practice who
require an analgesic-antipyretic?

Precautions and Adverse Reactions:
If a rare sensitivity reaction occurs, the drug should be stopped.
TYLENOL (acetaminophen) has rarely been found to produce any side effects.

Supplied: Tablets, 325 mg.
For Children:
Elixir, 120 mg./5 cc. (alcohol 7%).
Drops, 60 mg./0.6 cc. (alcohol 7%).
Chewable Tablets, 120 mg.

Safer than aspirin, yet just as effective for relief of pain and fever

Tylenol®
(acetaminophen)

McNEIL McNeil Laboratories, Inc., Fort Washington, Pa. 19034

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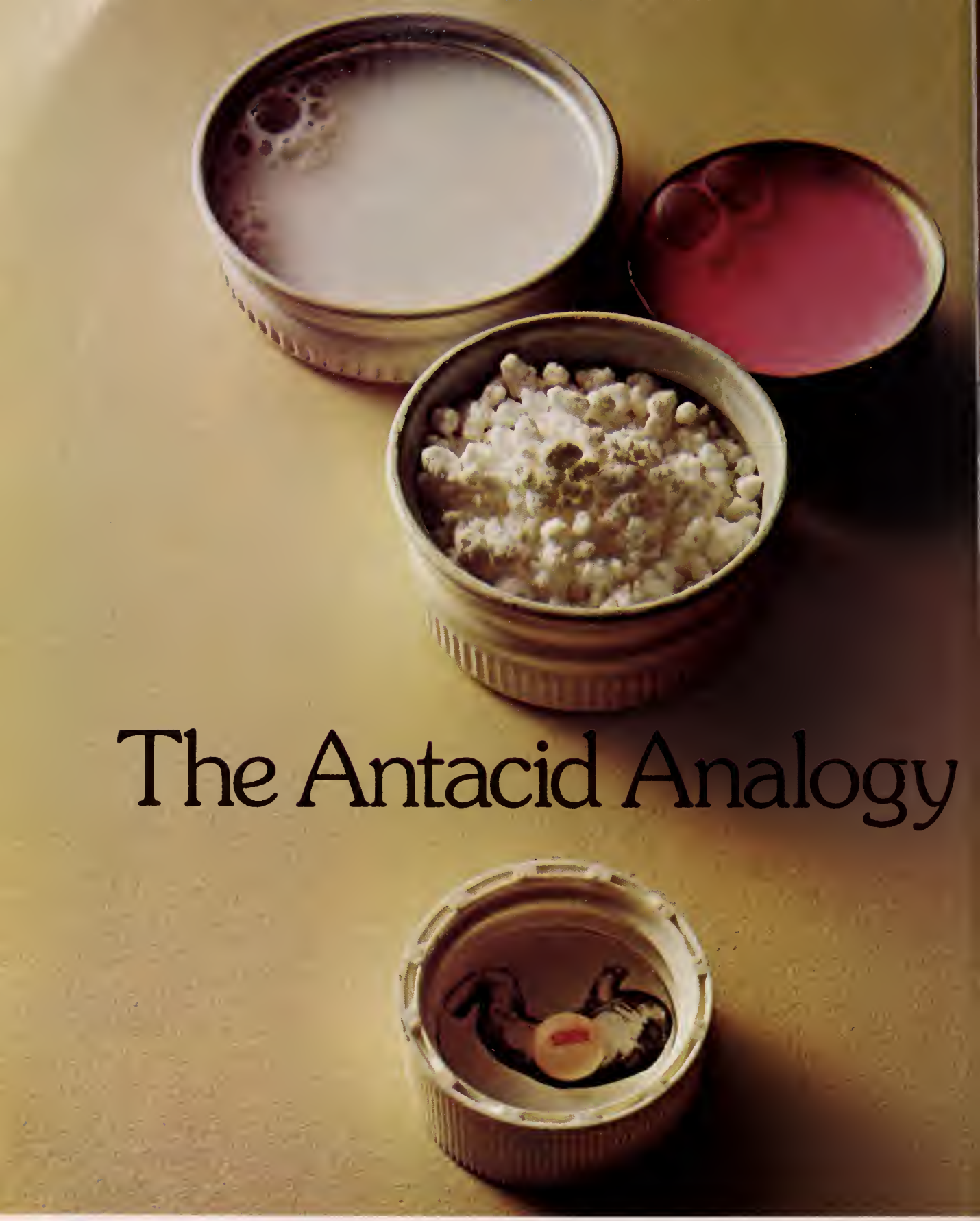

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution.

Fever and possibly heat stroke may occur due to anhidrosis.

In theory a curare-like action may occur, with loss of voluntary muscle control. For such patients prompt and continuing artificial respirat should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenc by elderly males with prostatic hypertrophy, such patients should advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerat colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions n

Therapeutic comparisons in peptic ulcer.

ntacids have only one mode of action to relieve ulcer pain...

Pro-Banthine® has four.

and of
propantheline bromide

ntacids:

ntacids relieve ulcer pain by neutralizing gastric id. This action is relatively short-lived and they have other mode of action.

ro-Banthine:

ro-Banthine suppresses gastric acid ecretion. The antisecretory properties of o-Banthine are well established. By effectively ocking vagotonic impulses Pro-Banthine suppresses stric secretion to reduce both total and free acid.

ro-Banthine helps relieve pain. o-Banthine relieves ulcer pain by reducing gastric cretion and the motility and spasm of the strointestinal tract.

Pro-Banthine reduces acidity without subsequent acid rebound. The capacity of Pro-Banthine to reduce the secretion of total and free acid in the stomach has been demonstrated in scores of studies. None has demonstrated any significant evidence of acid rebound.

Pro-Banthine activity lasts about six hours. The effect of a single therapeutic dose (15 mg.) of Pro-Banthine lasts about six hours.* Pro-Banthine P.A.®, the prolonged-acting form, is active from 8 to 12 hours. Thus Pro-Banthine may be used to suppress acid, spasm, and pain around the clock, even during the sleeping hours when antacids, to be effective, must be taken almost hourly.

*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

Pro-Banthine complements and enhances the action of antacids.

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cur as well as mydriasis and blurred vision. In addition the following verse reactions have been reported: nervousness, drowsiness, dizziness, omnia, headache, loss of the sense of taste, nausea, vomiting, constipa-n, impotence and allergic dermatitis.

sage and Administration: The recommended daily dosage for adult l therapy is one 15-mg. tablet with meals and two at bedtime. Subse-ent adjustment to the patient's requirements and tolerance must be de.

o-Banthine P.A.—Each tablet of Pro-Banthine P.A. (propantheline omide) contains 30 mg. of the drug in the form of sustained-release or timed-release beads; on ingestion about half of the drug is released within an hour and the remainder continuously as earlier increments are metab-olized. Thus the result is even, high-level anticholinergic activity main-tained all day and all night in most patients with only two tablets daily. Some patients may require one tablet every eight hours.

The contraindications and precautions applicable to Pro-Banthine 15 mg. should be observed.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

Synthroid®

(sodium levothyroxine)

Supplied: **Tablets:** 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded in bottles of 100, 500, and 1000.

Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, U.S.P., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent.

Synthroid-T_4

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Deerfield, Illinois 60015

Dr. John Dunn, a Creighton graduate who has been practicing in Elgin, Nebraska, will supervise the office. Dr. Haller said patients will be charged what they can afford to pay. Health Center staff members are on the university payroll. If income exceeds expenses, the money will be used to support Creighton's Family Practice program.

WashingtoNotes

Wage-price controls

Congress has dealt a mortal blow to the Administration's plan to continue wage-price controls on physicians, hospitals and nursing homes after April 30.

The Senate Banking Committee voted 11 to 4 against a compromise plan that would give the Administration standby authority to keep controls on some industries after the April 30 cut-off when the controls program expires. The Committee then unanimously voted to kill the Administration program to keep the lids on health while freeing the rest of the economy.

Barring an unexpected shift in Congresional sentiment, the control program is dead.

Blood

The AMA is playing a guiding role in an attempt to establish an American blood commission that would assure a national, all-volunteer supply of blood for transfusions and medical emergencies by December 31, 1975.

The plan was made public by Richard E. Palmer, M.D., now chairman of the AMA board of trustees, and spokesman for the major groups involved in collecting, distributing, and using blood.

Other major sponsors of the proposed American Blood Commission include the American National Red Cross, the American Association of Blood Banks, and the Council of Community Blood Centers.

The proposed plan is for a volunteer program controlled at the local level, with medical societies playing a major role. Some 150 national groups with an interest in a safe blood supply would be members of a commission that would oversee each regional program. The regional programs in turn would guide the activities of blood banks and transfusion facilities in their own area.

In the non-profit field, the American Association of Blood Banks (AABB) and the American National Red Cross have vied for the leadership role. The non-profit blood banks — largely hospital units — chiefly have favored a non-replacement fee for blood as the most dramatic way of attracting donors, whereas the Red Cross traditionally has relied on strictly volunteer blood.

Government's heavy hand

The AMA has warned Congress that legislation before it would treat the health sector as "one vast, monolithic public utility" with the Secretary of Health, Education and Welfare "a health care czar."

Testifying before the Senate health subcommittee on a bill sponsored by Senator Edward M. Kennedy (D., Mass.), AMA President Russell B. Roth, M.D., termed the bill "one of the gravest steps to be proposed concerning health care delivery." The measure calls for replacement of Comprehensive Health Planning and Regional Medical Programs by a formal planning system coupled with public utility regulations by state health commissions under HEW supervision.

A major provision of the legislation would require the state health commissions "to determine prospectively rates used for reimbursement purposes for health services of health care providers within the state and

regulate all reimbursements if such health care providers made on either a charge, cost, negotiated, or other basis and review such rates at least once a year."

Pension

Despite a strong labor-backed move to the contrary, the House easily approved legislation allowing self-employed people such as lawyers and physicians to deduct from federal income taxes up to $7,500 a year provided it is placed in a qualified pension plan.

The Senate had already approved the provision — part of an overall pension reform bill — making chances of final Congressional enactment and signing into law almost certain.

The current Keogh program limitation on tax deferrals for retirement is $2,500 not to exceed ten percent of income. The new provision allows $7,500 not to exceed fifteen percent of income.

Spokesmen for the provision, including the AMA, urged lawmakers to approve on grounds the cost of living has increased dramatically since the Keogh Law was last liberalized.

The legislation for the first time imposes certain limitations on corporate retirement programs including those for so-called professional service corporations. Tax deferrals will not be allowed on savings that would exceed a pension that brings in more than 75 percent of highest earnings over a three-year period or $75,000 a year, subject to cost-of-living allowances in the future. A grandfather-clause exempts people eligible for more than $75,000 based on current compensation and additional period of employment.

PSRO

A total of 203 areas have been designated for Professional Standards Review Organizations (PSROs) by DHEW, 21 more areas than tentatively proposed last December. Major change was allowing two larger states —Georgia and Washington — to operate as single PSRO areas.

The final area designations — published in the Federal Register — were handed down after a month-long review of hundreds of comments from physicians groups.

The most significant change in the final regulations was naming Georgia and Washington as single PSRO areas. Both states have more than 5,000 physicians, and had been divided into three PSRO sections each. In the earlier proposed regulations, HEW had indicated it would hew to the 2,500 - 3,000 physician limit for a PSRO area. Many states and the AMA had urged HEW to permit some states with higher physician populations to serve as single PSROs.

All told, 31 states and territories will serve as single PSROs; 22 as multiple PSROs.

HEW invited applications for contracts from qualified physician organizations to plan PSROs, to begin operation of PSROs on a conditional basis, or to establish statewide organizations to provide support services to local PSROs.

The head of the PSRO program said the new statewide Support Center Plan would give large state medical societies essentially what they sought in their fight for single-state PSRO status.

Henry Simmons, M.D., told AM NEWS that the larger states never intended to do the review and standard setting on a statewide basis. According to Dr. Simmons, those states wished to provide the leadership and support for PSRO in their states.

Gasoline

Within hours after Drs. James Sammons and Richard Palmer, representing the AMA board of trustees, called upon energy czar William Simon with respect to the effect of gasoline shortages on physicians and their care of patients, Simon wired a statement to all state governors suggesting that they establish a special rule to assure adequate gas for medical personnel, and other essential public services.

Coming Meetings

CRIPPLED CHILDREN'S CLINICS—
May 11 — North Platte, Elks Lodge
May 25 — Ainsworth, Elm Grade School
June 29 — Hastings, Elks Lodge

SEMINAR ON ADVANCES IN PEDIATRICS — 14th Annual, at Childrens Memorial Hospital, Omaha, June 6, 7, and 8, 1974. The Seminar is jointly sponsored by the Hospital, Creighton University School of Medicine, and the University of Nebraska School of Medicine. Speakers will include: Dr. H. William Clatworthy, Ohio State University, Pediatric Surgery; Dr. George H. McCracken, Jr., University of Texas, Infectious Disease; Dr. Omar Burgert, Mayo Medical School, Hematology - Oncology; Dr. Joseph E. Ghory, Convalescent Childrens Hospital, Cincinnati, Ohio, Allergy; and faculty members of both local Medical Schools. The registration fee is $50 and includes continental breakfast and lunch. Write: Seminar Committee, Childrens Memorial Hospital, 44th and Dewey, Omaha, Nebraska 68105 for further information.

AMERICAN MEDICAL ASSOCIATION — Annual Convention, June 22 - 26, 1974, McCormick Place, Chicago, Illinois.

AMERICAN CANCER SOCIETY'S NATIONAL CONFERENCE ON GYNECOLOGIC CANCER; September 18-20, 1975, Marriott Hotel, Philadelphia, Pennsylvania.

AMERICAN CANCER SOCIETY — National Cancer Institute — Eighth National Cancer Conference; September 20-22, 1976, Regency Hyatt Hotel, Atlanta, Georgia.

NEBRASKA MEDICAL ASSOCIATION — Fall Session, October 3-5, 1974, Lincoln, Nebraska.

OMAHA MID-WEST CLINICAL SOCIETY — 42nd Annual Postgraduate Assembly, November 11, 12, and 13, 1974, Omaha Hilton Hotel. Write to: (Mrs.) Mary E. Pilloud, Executive Secretary, 1040 Medical Arts Building, Omaha, Nebraska 68102.

AMERICAN ASSOCIATION FOR CLINICAL IMMUNOLOGY AND ALLERGY — Annual Meeting; Pier 66, Ft. Lauderdale, Florida, November 21-24, 1974. Write to: John L. Dewey, M.D., P. O. Box 912, DTS, Omaha, Nebraska 68101.

AMERICAN CANCER SOCIETY — National Cancer Institute — National Conference on Advances in Cancer Management; Part I, Treatment and Rehabilitation, November 25-27, 1974, Waldorf-Astoria Hotel, New York City.

AMERICAN MEDICAL ASSOCIATION — 28th Clinical Convention, November 30 - December 4, 1974, Portland, Oregon.

NEBRASKA MEDICAL ASSOCIATION — Annual Session, April 27 - 30, 1975, Lincoln, Nebr.

AMERICAN CANCER SOCIETY — National Cancer Institute — National Conference on Advances in Cancer Management; Part II, Detection and Diagnosis, May 1-3, 1975, The Denver Hilton, Denver, Colorado.

NCME PROGRAMS

April 22 - May 5

DIGITALIS: FRIEND OR FOE?

HERPES SIMPLEX: VIRAL DILEMMA.

THE TREATMENT OF ACNE.

May 6 - May 19

HOME MANAGEMENT OF ARTHRITIS.

SENSORY FEEDBACK THERAPY.

ZOSTER: A LATENT THREAT.

Medicinews

JCAH releases studies

The Joint Commission on Accreditation of Hospitals (JCAH) has announced the release, in printed from, of two year-long studies which index hospital-based capabilities to provide various levels of care for patients with heart disease or cancer.

The studies, which were contracted for by the Department of Health, Education and Welfare, Regional Medical Programs Service (RMPS), were undertaken by the Joint Commission's Listing Program for Specialized Clinical Services (LP/SCS). The heart and cancer studies, along with previously completed studies on kidney disease and stroke, complete the present contract.

Dr. John D. Porterfield, Director of the Joint Commission, said, "It is extremely important that medical professionals who perform in these areas of concern take this opportunity to review and comment on these studies before final approval and adoption of the criteria by the Joint Commission. That's the reason we are publicizing the availability of these studies."

The first study, "Optimal Criteria for Care of Heart Disease Patients," classifies the entities of care available in hospitals by these categories:

A. Hospitals providing basic and limited services;

B. Hospitals providing selected, advanced, specialized services;

C. Hospitals providing comprehensive specialized services, (e.g., community hospitals and regional heart centers); and

S.* Children's hospitals providing comprehensive specialized services to pediatric heart patients.

The second study, "Optimal Criteria for Care of Patients with Cancer," classifies the entities of care using the following descriptive categories:

I. Hospitals providing comprehensive specialized services and advanced specialty training and research;

II. Hospitals providing comprehensive specialized services;

III-A. Hospitals providing basic and selected specialized services; and

III-B. Hospitals providing basic services primarily.

Copies of the heart and cancer studies, as well as the kidney and stroke studies, are available at no charge from John D. Porterfield, M.D., Director, Joint Commission on Accreditation of Hospitals, 875 North Michigan Avenue, Chicago, Illinois 60611.

The Joint Commission is a nongovernmental, not-for-profit organization. It sets accreditation standards and provides survey services through which health and specialized service facilities can measure and improve the quality of care they provide to consumers. JCAH has accreditation programs for most types of hospitals, long term care facilities, psychiatric facilities, and facilities for the mentally retarded.

Medicare services

HEW Secretary Caspar W. Weinberger has outlined conditions under which Medicare will pay for services not covered by the law either because they were not "reasonable and necessary" or involved "custodial care."

Under proposed regulations:

Medicare will pay for the services if neither the person who received the services nor the person who furnished them knew, or could reasonably be expected to know, that the services were not covered.

If the provider of services, or the physician or other person in an assignment case, knew or could reasonably be expected to know that the services were not covered, then neither Medicare nor the beneficiary will be liable for payment.

If in these cases the beneficiary is charged for the noncovered service, Medicare will repay the beneficiary and charge the amount to the provider of services or the physicians. The provider or physician will then have the right to contest the decision through the administrative appeals process and through the courts where applicable.

When a provider is found to have made all reasonable efforts to obtain knowledge of Medicare coverage and to apply that knowledge, the proposed regulations permit a presumption that the provider did not have knowledge of non-coverage in a particular case, in the absence of evidence to the contrary. This presumption can be applied only if the provider meets criteria which are set forth in the proposed regulations.

Final PSRO designations made

In a press release, HEW Secretary Weinberger announced the final designations of local PSRO areas. When the proposed designations were made on December 20, 1973, 182 areas were specified. Under the final designations there were 203 geographic areas in which PSRO's are to be formed. In announcing the areas, the Secretary indicated that "HEW is now prepared to accept applications for contracts from qualified physician organizations to plan PSRO's, to begin operation of PSR0's on a conditional basis, or to establish statewide organizations to provide support services to local PSRO's." Under these final designations, 29 states plus the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, and the Trust Territories of the Pacific Islands will each be designated as single state PSRO areas. This is three more states, Hawaii, Georgia, and Washington, then was designated previously. Texas has been increased from 8 to 9 PSRO areas, Michigan from 8 to 10, Florida from 8 to 12, and California from 21 to 28 areas. The Secretary indicated that the deadline for submission of proposals for planning contracts was April 15, 1974 and that the deadline for conditional designation contract proposals and for contract proposals to provide technical assistance was April 30, 1974.

Chronic ear disease

The Department of Otolaryngology of the University of Illinois, Abraham Lincoln School of Medicine, is pleased to announce a Workshop on the Surgery of Chronic Ear Disease to be held October 2 through 4, 1974.

The workshop will deal with canal preservation in surgery for cholesteatoma. The technic of canal preservation will be taught by closed circuit surgical color television and temporal bone dissection. Seminars will be held to discuss the difficulties and complications of these technics.

Under the direction of David F. Austin, M.D., the faculty is composed of an international group of clinicians.

Registration includes all materials, lunches and transportation about the city, and is limited to 50.

Interested registrants may write directly to the Department of Otolaryngology, University of Illinois Hospital Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, Illinois 60612.

Administration's health planning bill

Sen. Javits (R), N.Y., has introduced S. 3166, the Administration's Health Resource Planning Act. This bill replaces current authority for CHP, RMP, Hill-Burton, area health education activities, and assistance for experimental health services delivery systems. The bill provides assistance for the formulation of a nationwide network of health systems agencies, which would be responsible for fostering alternative health care arrangements, the elimination or reduction of health resource duplication, the establishment of an adequate supply and distribution of resources, the improvement of the efficiency and productivity of health care providers, the continuing education of health personnel, and the coordination of all segments of the health care market. The governor of each state would designate geographical regions within the State as health service areas, each of which would be served by a health systems agency (HSA) certified by the Secretary of HEW. The Secre-

tary would make grants for the operational expenses of an HSA and provide it with a broad range of technical assistance and technical assistance grants and contracts to further the comprehensive health plan for its health service area. The HSA would have to be nonprofit, private corporations which are not providers or insurers of health services or an educational institution. One-half of an HSA governing body would have to represent consumers or state or local officials. The other half would represent health care providers and institutions.

The bill also establishes a formula grant program to assist the states in paying the costs of regulating capital expenditures related to health care and otherwise to establish or regulate rates used for the payment of health care services. The formula grant allotment would be in accordance with the populations of the respective states and the costs of regulating these activities. If a state regulates both capital expenditures and rates of payment or reimbursement for health care services through a central, single state agency, its allotment would be increased by 25%.

Medicare alternative offered

Sen. Ribicoff (D) Conn., has introduced S. 3154 the Comprehensive Medical Reform Act of 1974, which would establish a "single integrated program of comprehensive health insurance for the aged and disabled financed out of general revenues." The present parts A and B of medicare would be combined into a single, expanded benefit structure with a single trust fund. The bill would eliminate present medicare requirements for premium payments and deductibles, but would contain certain coinsurance requirements. It would provide for medicare coverage to all citizens, nationals or resident, aliens 65 years of age or older, and would expand medicare benefits to include unlimited inpatient hospitals coverage, 150 days of care during a benefit period for psychiatric inpatient treatment, unlimited outpatient hospital coverage, unlimited skilled nursing facility services, unlimited intermediate care facilities services, and unlimited home health services. Also included would be unlimited physicians services, certain psychiatric services, unlimited dental services, medically necessary devices, outpatient prescription drugs, services of optometrists, podiatrists, and chiropractors, as well as certain other services. The bill would incorporate all present medicare cost control and utilization review provisions. Reimbursement to participating institutional providers would be based upon a predetermined schedule of patient care charges. Reimbursement for the services of noninstitutional providers would be made in accordance with annually predetermined fee schedules for local areas. The bill would require that participating physicians accept assignment. No cost estimates were given for the bill.

The Letter Box

To the Editor:

We would like to offer this pamphlet gratis to your readers.

HEALTH EFFECTS ON ENVIRONMENTAL POLLUTION: *Illustrated 24-page color booklet describing various adverse effects that the pollution of the environment has on human beings.* Particularly useful to physicians and other medical practitioners, the booklet gives the reader some insight on the role of the environment in "causing" diseases like bronchitis. Is the psyche affected by lead, or mercury, or noise exposure? Can odors hurt you? How are some chemicals not only carcinogenic, but teratogenic or mutagenic? These are the kinds of questions raised and discussed. *Available free from Office of Public Affairs, Dept. MED, U.S. Environmental Protection Agency, Washington, D.C. 20460.*

Many thanks for your assistance.

Sincerely yours,

Charles M. Rogers
Assistant Director of Public Affairs Communications Services

Dear Dr. Cole:

I just wanted to drop you a short note to let you know how much we enjoyed your editorials in your January issue. I hope you will grant us permission to reproduce some of them from time to time as short items in *Medical Times*.

Sincerely yours,
James F. McCarthy
Managing Editor

Books

Books reviewed

Interpretation of Audiometric Results, by Irving Hochberg; 45 pages; soft cover; 15 by 23 cm (6 by 9 in); published 1973 by Bobbs-Merrill Co., Indianapolis & New York.

This booklet is one of the Bobbs-Merrill studies in communicative disorders. There are no chapters and there is no index, but the paper, as the author calls it, is divided into pure tone audiometry, interpreting the pure tone audiogram, the diagnostic value of the pure tone audiogram, audiologic features of hearing loss, speech audiometry, differential diagnosis of audiometry, disorders of the central auditory nervous system, and functional hearing loss.

The author is associate professor in the department of speech and theater, Speech and Hearing Center, Brooklyn College, CUNY. He has been consultant in audiology for three NYC hospitals and is president of the New York State Speech and Hearing Association; his articles have appeared in several professional journals.

It is long for a paper and small for a book, and I wish it had an index. But I like little books, and I do like this one.

—F.C.

Current Pediatric Diagnosis and Treatment, edited by C. Henry Kempe, M.D.; Henry K. Silver, M.D., and Donough O'Brien, F.R.C.P.; 1020 pages; limp cover, $12.00; 18.5 by 26 cm (7¼ by 10 in); published 1974 by Lange Medical Publications, Los Altos, California.

This is a big book about little patients. It is in its third edition, having appeared before in 1970 and in 1972. There are no less than 51 authors, including the three editors. The book is divided into 38 chapters, which are well written. There are enough tables, and a sprinkling of figures.

The printing is good, and the editors have provided us with a large three-column index. Chapter is an interpretation of biochemical values, which is a 25-page series of tests and both normal and abnormal values, and is alone worth the price of the book.

The book is as modern as today's newspaper, even moreso. If it helps you treat one child, what's 12 dollars? Books are often worth more than they cost, but this one is a bargain.

—F.C.

Received

A Handbook of Human Service Organizations, by Harold W. Demone, Jr., Ph.D., and Dwight Harshbarger, Ph.D.; 600 pages; hard cover $19.95; 16 by 23.5 cm (6¼ by 9¼ in); published 1974 by Behavioral Publications, New York.

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Advertisements in this column are at a rate of ten cents per word with a minimum of $4.00 per insertion. Copy must be received by the fifth of the month preceding date of publication and should not exceed 50 words. Advertisements from members of the Nebraska Medical Association will be accepted without charge for one issue. Each advertisement will be taken out following its first appearance unless otherwise instructed. Where numbers follow advertisements, replies should be addressed in care of The Nebraska Medical Journal, 1902 First National Bank Building, Lincoln, Nebraska 68508.

GENERAL PRACTITIONERS NEEDED — County seat town, North-Central Nebraska. Clinic available across street from modern 34-bed hospital. Three nursing homes nearby, large trade area. Affiliation possible if desired. If interested, call or write Charles Sweet, M.D., 140 South 4th; Roy J. Smith, M.D., 732 West Fairview; or Administrator, Boone County Community Hospital, Albion, Nebraska 68620.

IMMEDIATE OPENING — For Ob-Gyn., Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

CLINIC AVAILABLE — General practice in furnished clinic. County seat town, SW Nebraska. Three nursing homes in town, good territory. Equipped office available for dentist. Write Box 8, Beaver City, Nebraska 68926.

MEDICAL OFFICE FOR RENT OR LEASE — Cot-Nor Incorporated Suite 500 with 1,015 sq. feet located at 5440 South Street, Lincoln, Nebraska. Abundant parking available. If interested, contact Mr. Dick Gaughan, Manager of Cot-Nor Incorporated, Suite 1600, 5440 South Street, Lincoln, Nebraska 68506. Phone: (402) 489-2718.

WANTED: FAMILY PRACTITIONER to join 8-man multi-specialty group. Outstanding clinic and hospital facilities. Unusually progressive small community in which to live and raise a family. Excellent salary and benefits, partnership in twelve months, liberal vacation and meeting time. Contact Richard A. Callis, Administrator, McCrary-Rost Clinic, Lake City, Iowa 51449. Telephone: 712-464-3194.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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MAY 15 1974

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for relief of excessive anxiety

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(chlordiazepoxide HCl)

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The Nebraska Medical Journal

June, 1974

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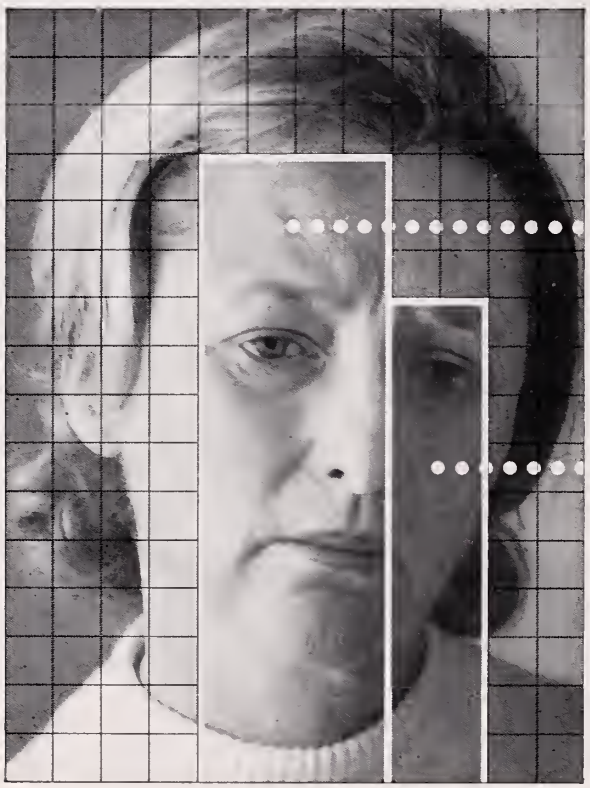

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The Nebraska Medical Journal

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The post-T&A patient:
another type for Tylenol
(acetaminophen)

When the post-T & A patient requires an analgesic, a new problem arises. Hemorrhagic tendencies following the use of aspirin after tonsillectomies have been reported.[1,2] In a patient who "...has recently undergone a surgical procedure or has another underlying hemostatic defect, aspirin ingestion may cause significant bleeding....Aspirin is absolutely contraindicated in such situations. Acetaminophen...could replace aspirin in these instances."[3]

The post-T & A patient is only one of several 'types for TYLENOL'—that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Reuter, S. H., and Montgomery, W. W.: Arch. Otolaryng. *80*:214-217 (Aug.) 1964. **2.** Osol, A., et al., ed.: The United States Dispensatory and Physicians' Pharmacology, ed. 26, Philadelphia, J. B. Lippincott Co., 1967, p. 171. **3.** Schwartz, A. D., and Pearson, H. A.: J. Pediat. *78*:558-560 (March) 1971.

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Illustrations should be numbered and their locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be in black (India ink) on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

Manuscripts (original, not a carbon) should be sent directly to the Editor at the Journal's address.

Letters to the Editor submitted for publication should be prepared as above, and must carry the notation: To be Published.

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Medicinews . . .

HEW proposes new payment plan under Medicare

HEW Secretary, Caspar W. Weinberger, recently announced a proposal under which Medicare would "pay for services not covered by the law either because they were not 'reasonable or necessary' or 'involved custodial care'." The proposed regulations are based upon section 213 of P.L. 92-603 which deals with the reimbursement of patients, providers and practitioners (when rights have been assigned) with respect to the reimbursement of services found to be unreasonable or unnecessary, or were custodial in nature. Under the proposed system, the Medicare system would pay for the services when neither the person who received the service nor the person who furnished it could reasonably be expected to know if the services were covered. If the provider of services or the physician knew, or could reasonably be expected to know, that the services were not covered, then neither Medicare nor the beneficiary would be liable for payment. Presently, if the beneficiary were charged for the non-covered service, Medicare would repay the beneficiary and charge the amount to the provider of services. The proposed rule would establish a system of presumption under which certain providers would be presumed to lack knowledge of non coverage in specific cases, in the absence of evidence to the contrary.

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Children of Adult Survivors With Spina Bifida Cystica — C. O. Carter (Institute of Child Health, London) and K. Evans. Lancet 2:924-926 (Oct 27) 1973.

A consecutive series of patients with spina bifida cystica, identified from the records of the Hospital for Sick Children and St. Bartholomew's Hospital before 1954, were studied to estimate the risk of neural tube malformation in the children of such patients who survive to adulthood. The 215 survivors who were traced had a total of 104 children, two of whom have a neural tube malformation. Of 100 male survivors, 14 had a total of 35 children, one of whom had spina bifida cystica. Of 115 female patients, 38 had a total of 69 children, of whom one had anencephaly. An estimate for risk to offspring of either sex is about 3%. The risk to children of male patients is at least as high as that of female patients.

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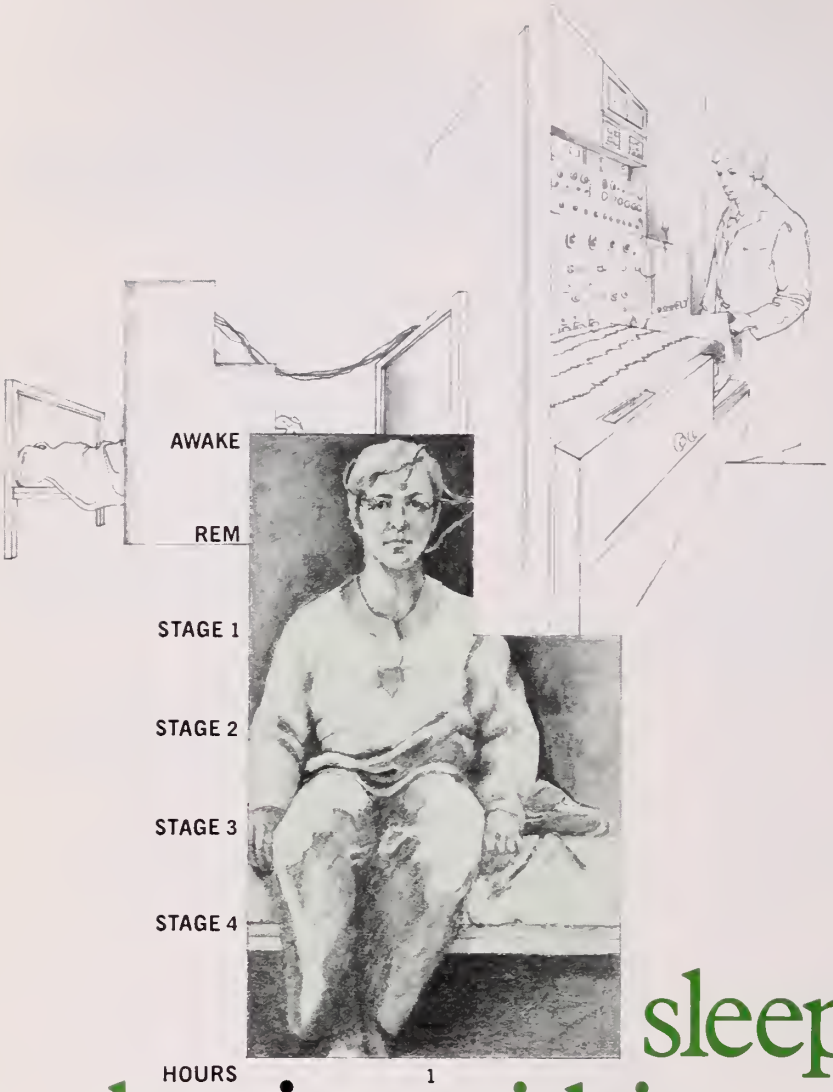

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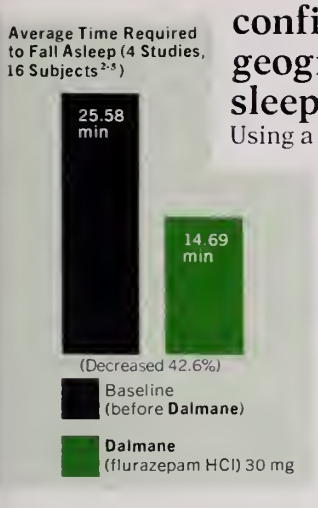

confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage[2-5]

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Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
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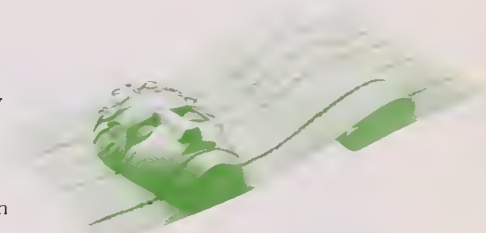

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REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
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4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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Opinion & Dialogue

Is there a need for a drug compendium?

Government Health Official

Henry E. Simmons, M.D.
Deputy Assistant Secretary for Health
Department of Health, Education and Welfare

A drug compendium of the type I envision would fill a definite need for the practicing physician. Such a compendium would give him all the information necessary for using a drug intelligently, and it would do so in a clear, concise, convenient, objective and balanced fashion.

What a Compendium Should Contain

I believe the compendium should inform the doctor what a drug will do, when he should use it for what type of patient, for how long, in what dose, what benefits his patient is likely to obtain, the risks involved, and cross-reactions with other drugs.

The information would be based on the package insert and have the same legal status. In fact a complete compendium with complete and current information might even eliminate the necessity

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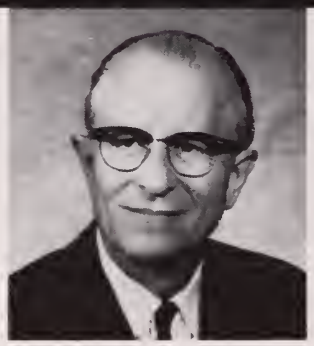

A drug compendium, or preferably compendia, should, I believe, be private, not federal, in sponsorship. They should contain comprehensive listings of drugs available for prescribing. They should be single, legibly printed volumes of reasonable size, updated quarterly or semiannually and completely revised every year

Function of a Compendium

A compendium should furnish the following information on drugs in the following order: indications for use, side effects, adverse drug reactions, contraindications, drug interactions, drug dosage and the dosage forms marketed. Drug prices should not be included because they vary so widely and change rapidly.

No compendium should set forth drugs of choice or discuss relative efficacy. Such questions must be left for the practicing physician to decide, whether on the basis of the medical literature, his own clinical experience, advice of colleagues, information supplied by manufacturers, and so on.

Nor should a compendium undertake to educate the doctor on how to use drugs. Rather, it must be a reference source designed primarily to refresh his memory as to drugs he may not use regularly. It

for a package insert in many instances. This would constitute a substantial saving for the manufacturer.

By a complete compendium, I do not mean a volume of prohibitive size. You don't need a book describing 25,000 products with an enormous amount of repetition. Rather, drugs should be arranged by class. Mutually applicable information would be provided, along with brief discussions pinpointing differences in specific drugs of that class. Listings would be cross-indexed in a useful way.

Other Available Documents as Sources of Information

Existing references such as PDR and the AMA Drug Evaluation are obviously useful but they are incomplete. Either they are not cross-referenced by generic name and do not group drugs with similar characteristics, or they do not list all the available and legally marketed drugs. And some of those omitted may be very useful. On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

---

should in no way imply control over the practitioner's prerogatives.

Why Another Compendium?

A practicable, single-volume compendium cannot, nor is it necessary to, include all drugs on the market today. From my practice of internal medicine for some 15 years, my experience as a consultant, and as a faculty member of four or five medical schools, I would estimate that a doctor uses only 30 to 35 drugs regularly. The 1972 Physicians' Desk Reference, incidentally, contained about 2,500 entries.

As to whether there should be a federal compendium, in my opinion, as stated earlier, the answer is easy—there should *not* be one. The proposal assumes that existing compendia are inadequate. We're not sure of that at all. Whatever its imperfections, the present drug information system in the U.S. is open, multifaceted, pluralistic and extensive. Good compendia exist, as well as other ample sources on drug therapy, ranging from journal literature through AMA Drug Evaluation to company materials. Not all physicians may use such sources as often or as well as they should, but that is the fault of the man, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

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VA appoints

The appointment of Dr. John D. Chase, 53, a Veterans Administration career medical official for 22 years as Chief Medical Director of the VA, was announced by Administrator of Veterans Affairs Donald E. Johnson.

Also announced was the appointment of Dr. Laurance V. Foye, Jr., as deputy chief medical director of the agency. Dr. Foye presently is VA's assistant chief medical director of academic affairs.

Dr. Chase will succeed Dr. Marc J. Musser when the present chief medical director retires April 15. Dr. Foye replaces Dr. Benjamin B. Wells who retired last January 23 to become vice president for medical relations with the National Pharmaceutical Council.

M.D. pay bill clears conference

House and Senate conferees have reached agreement on S. 2770, which authorizes special pay for medical officers in the uniformed services. Under the conference committee bill, bonuses of up to $13,500 a year would be authorized for medical officers who enter into active duty agreements with the uniformed services. The Senate passed bill had authorized bonuses of up to $10,000 and the House passed version called for bonuses of up to $15,000. The conference committee deleted special pay provisions relative to dentists, optometrists, and veterinarians which were contained in the House passed bill.

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Breast self-examination:

KEY ROLE OF THE PHYSICIAN

item:	Breast cancer is a major concern of American women, according to a recent Gallup study conducted for the American Cancer Society.
item:	Although aware that early discovery improves the chances of cure, and that BSE can lead to early discovery, *fewer than 1 in 5* women practice BSE, and *only half* have an annual breast examination by a physician.
item:	Only 35% of all women polled reported that a *physician* had ever raised the subject of breast self-examination, and only 24% had received instruction from the physician on how to do it. Even among women who regularly see a gynecologist, only 34% had been instructed on BSE.
item:	*But,* among women who received personal instruction from their physicians, the overwhelming majority *(92%)* practiced BSE during the preceding year.

The Gallup study revealed that, far more important than increasing awareness of breast self-examination, is the problem of inducing women to practice it regularly. The physician plays a key role in this—by teaching women the correct technique, and instilling in them the confidence that will assure their continued practice of BSE.

The American Cancer Society gives major emphasis to breast cancer through research and a vast array of public educational materials, designed to give women life-saving information about the disease. Our latest approach is via a pioneering television film starring Jennifer O'Neill, "Breast Cancer: Where We Are." Where we *will* be in a few years will certainly hinge on our joint efforts.

American Cancer Society®

Complications of Coronary Arteriography — D. F. Adams et al (Harvard Medical School, Boston 02115). Circulation 48: 609-618 (Sept) 1973.

A nationwide survey was undertaken to determine the rate of complications due to coronary arteriography during 1970-1971. The responses from 173 hospitals, including a total of 46,904 coronary arteriograms, were analyzed in relationship to the techniques employed and to the number of exams performed at each hospital during the two-year period. Overall mortality was 0.44% (brachial 0.12%, femoral 0.78%). Mortality in institutions performing fewer than 200 exams/two years was eight times higher than in those performing more than 800 exams/two years. The incidence of myocardial infarction and cerebral embolism was significantly higher when a smaller number of exams was performed. The incidence of major complications, including death, myocardial infarction, and cerebral embolism, was higher in exams using the femoral approach than the brachial approach. Incidence of arterial thrombosis and contrast agent reactions was higher for the brachial approach.

Evaluation of Clinical Competence Through Study of Patient Records — H. M. Scott (McGill Univ Clinic, Montreal) and A. Sniderman. J Med Educ 48:832-839 (Sept) 1973.

A method requiring modification of patient records to include not only what was done, but also the recommendations of more junior members before consultation with superiors, is described. From the analysis of the records so obtained, scores referable to subcategories of clinical problem-solving, and major errors were derived. It is demonstrated how such evaluation can then be used to guide individual and team development, both in direct patient management and other more indirect aspects of competence as supervisory skills.

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THE NEBRASKA MEDICAL JOURNAL

ON WASTING

We die of only some five things, inflammation, infection, degeneration, malignancy, and trauma. And unless injury does us in, we usually die slowly, which, as Caesar and others have said, is not the best way to go. When we take a long time to die, we waste away. We get the elevenses, we weigh less, we look thin. We are likely to take in our belts and tighten our collars.

What parts of us go before we do? Fat and muscles, I think. Not the skin, it hangs loosely and betrays us. Not our bones; and if solid and hollow viscera become lighter, it is probably because of their fat and muscle. We have fatty tissue, but fat is not really a tissue; muscle is.

Muscle is everything in life, and it is the first to go in death. Muscle is strength, it is flesh, it is another name for meat. When the muscles go, we go.

But if muscle is so strong and so vital, why is it the first to leave the sinking ship?* I think it's because it's what makes us go. The heart pumps blood so the muscles can work, the brain tells the muscles to contract and not to let go. We are nothing without our muscles.

And when we waste away, we lose our muscles, our strength, and our lives.

*The word muscle comes from the Latin word for mouse.

—F.C.

HOW CLEAN CAN YOU GET?

I have bought luncheon meat in a store and the man behind the counter cut it with a knife that had been used to slice raw meat. I have been served cooked meat, and the salesgirl weighed it and then she held up the ready-to-eat meat with her bare hands to ask me if it was enough. In a grocery store where they prepare cooked food to take out, I saw a girl hold the food in her hands before serving it to me. And just now, in another place, I was given a sliced cooked meat sandwich, and I watched the man who made my sandwich take up all the meat in his hands to put the slices on the bread.

I do not think any of this is necessary, and the dose is surely increased by disregard for proper sanitary practice. If the laws are such as to approve of these procedures, I do not like them, and if they do not allow such handling of cooked food, it should not be done.

Is picking up cooked meat in bare hands before putting it in paper or in a sandwich a proper thing to do? I cannot think so. I do not know where the person who holds my food in his hands has just been, and I shudder to think. But there are such things as waxed paper and tongs and forks, and I believe people who handle food in stores and in restaurants ought to use them; two persons I know became violently ill after eating cooked food bought at one of these places.

The customer has no recourse in such a situation, and the food handler should not be allowed to spread disease. The consumer must be protected; we are in the twentieth century, and nearly in the twenty-first.

—F.C.

KEEP THEM ALIVE

There is a kind of mathematical proof called induction, where you show that if something is correct for a, then it is also right for a plus one; then you have only to demonstrate that it is true for 3, and you have it made. Then it works for 4, and of course for five, and so on, for ever and ever. Now if you want to keep alive, you can start with one year, then with two, and so on. What we do now is a sort of patchwork, lopping off cancers and strokes at the end, but doing little at the beginning to see that these things do not ever get started.

What would happen if we detected a tumor when it occupied only one cell, and then removed it? What would be the effect

of keeping blood pressure down forever, and preventing arteries from sclerosing and myocardia from infarcting? We could give a vitamin pill to a person every day of his life, and a tablet containing chemotherapeutic treatment for cancer before it even starts, and a capsule to keep you from getting tuberculosis and everything else that keeps us from being immortal.

The one year old would surely grow to two, and to three, and so on.

—F.C.

NAME ME NO NAMES FOR MY DISEASE

I have gone from asthma to zoophobia and there is nothing funny about disease. But I mean only to lighten the somber aura that surrounds our daily work, and so to suggest that the names we have assigned to pathological states may give us pause.

Consider:

Munchausen's syndrome.
AAA disease.
Pickwickian syndrome.
Doll's eye sign.
Syndrome of crocodile tears.
Chicago disease.
Four-day syndrome.
Alice in Wonderland syndrome.
Crazy disease.
Scimitar syndrome.
Plaster-of-Paris disease.
Frank's sign.
Cole's sign.

—F.C.

IT DOESN'T NEED TO BE A HUNDRED PERCENT

Not very long ago, doctors didn't get sued for anything; now they are sued for everything, and this is sad. In a famous story about operations, the patient-author said that it didn't seem fair when he was asked to sign something assuming responsibility for everything. But neither is it fair to hold the physician liable for everything that happens and for anything short of success.

For every illness has its complications, every operation its morbidity and mortality, every drug its side effects; and everybody dies.

I suggest to litigation-minded patients and to their legal representatives that hurling *res ipsa loquitur* at us is not fair: it is dishonest and wicked. We cannot be responsible for everything, we cannot assure success, we cannot keep people alive forever.

We ensure everything good for our patients, and we shield them from all that is unpleasant. But it doesn't need to be a hundred percent; it just can't.

—F.C.

IS SNEEZING DANGEROUS?

When you sneeze, does your heart stop? I thought I would look into it. I couldn't go around with an EKG hooked up to me all day, but I decided I would reach for my radial artery pulse when I felt a sneeze coming on.

I didn't get to it quickly enough the first time, and I forgot on the next occasion, but I made it finally.

It does stop. My pulse disappeared completely, and stayed away for an ominously long time; I thought it would never come back.

—F.C.

THE ANNUAL SESSION

The annual session has come and gone. It lasted five days. It was a great deal of work, through which the proper amount of fun was sprinkled at just the right times. The total attendance was 569, broken down as follows: physicians, 301; auxiliary members, 113; exhibitors, 66; guests, 33; medical students and interns, 56.

The average physician attendance during the preceding four years was 287. We talked of everything you can think of, excepting shorter hours. The program was good, and I enjoyed all the speeches. We changed leaders, and so did the ladies, and we both did well. I saw many of my friends, listened to some marvelous reference committee hearings, and came home tired, but happy.

—F.C.

Diagnosis of Pneumoperitoneum In the Adult

ROGER K. HARNED, M.D.*

THE prompt and correct diagnosis of a perforated viscus often depends upon demonstration of a pneumoperitoneum by roentgen examination. A supine (anterior-posterior) view of the abdomen many times is the first roentgenologic examination requested by the clinician in his evaluation of an acute abdomen. In rare cases the patient may be in such poor condition that the radiographic examination has to be limited to this single film. Therefore, the correct interpretation of a supine abdominal study can be of great importance in establishing the diagnosis of a perforated viscus.

It is our purpose in this communication to review the roentgen findings of pneumoperitoneum as seen in a supine view of the abdomen. We will then briefly discuss a more accurate roentgenologic technique to identify small increments of intraperitoneal air. These topics are well known to radiologists, but may not be as familiar to other physicians.

At least five signs of extra-alimentary air as seen on supine roentgen abdominal studies have been described.[5] However, only two of these roentgen signs have proven to be consistently present and reliable in our experience. They are usually seen together, but occasionally only one or the other will be apparent. These signs are:

(1) Visualization of the inner and outer margins of the bowel wall.

(2) Visualization of the falciform ligament with or without air extending to the flanks bilaterally.

On a normal abdominal roentgenogram the inner (mucosal) margin of the bowel wall is usually well seen contrasted against the air within the bowel lumen, while the outer wall of the bowel is not discernible. However, when air is present within the peritoneal cavity, as from a perforated viscus, the outer margin of the bowel wall can then be seen. Thus, both inner and outer margins of the bowel wall are visible when a pneumoperitoneum is present (Figs. 1 and 2). This sign was first described by Rigler in 1941.[4] He accurately stated that this finding is almost pathognomonic of pneumoperitoneum.

The falciform ligament is not seen on roentgenograms of the normal abdomen. It is only visible when surrounded by extra-alimentary air as from a gastrointestinal perforation. Under these conditions the ligament appears as a thin, gently curved density located in the medial portion of the right upper abdominal quadrant extending in an oblique direction (Figs. 1 and 2). Miller, in 1960, described the "football or air-dome sign" as diagnostic of pneumoperitoneum in infants.[3] This sign consists of an oval lucency in the central part of the abdomen divided in its cephalad portion by the falciform ligament. We have seldom seen the large oval lucency in adult cases of pneumoperitoneum but have found the falciform ligament commonly visible. In our cases, air extending to the flanks has occasionally been present in combination with visualization of the falciform ligament (Fig. 1).

Although these two signs are definitely helpful in diagnosing pneumoperitoneum, they are usually not present unless there is a large amount of intraperitoneal air as from perforation of the colon or stomach. Therefore, a supine abdominal study alone is of little value in establishing a diagnosis of perforation of the upper intestinal tract which involves a small quantity of extra-alimentary air.

Hodges, Miller,[2] Freimanis, and Nelson[1] have described a simple and accurate method

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which requires a definite sequence of film exposures to detect as little as one or two cubic centimeters of extra-alimentary air. We have used this method over the past three years and have increased our diagnostic accuracy for pneumoperitoneum. A very essential part of the Miller-Nelson technique entails the use of a chest roentgenogram. A chest film almost always should be included in the evaluation of an acute abdomen for the following reasons:[1]

(1) Patients with primary chest disease such as pnemonia will often have referred pain to the abdomen mimicking the pain of peritonitis. This is especially true in children.

(2) An upright chest film is more accurate than an upright abdominal study in demonstrating intraperitoneal air. The central beam of the x-ray is centered more to the diaphragm in a chest roentgenogram resulting in less divergence of the x-rays. Often the diaphragm will not be included in an upright abdominal film, especially if the pa-

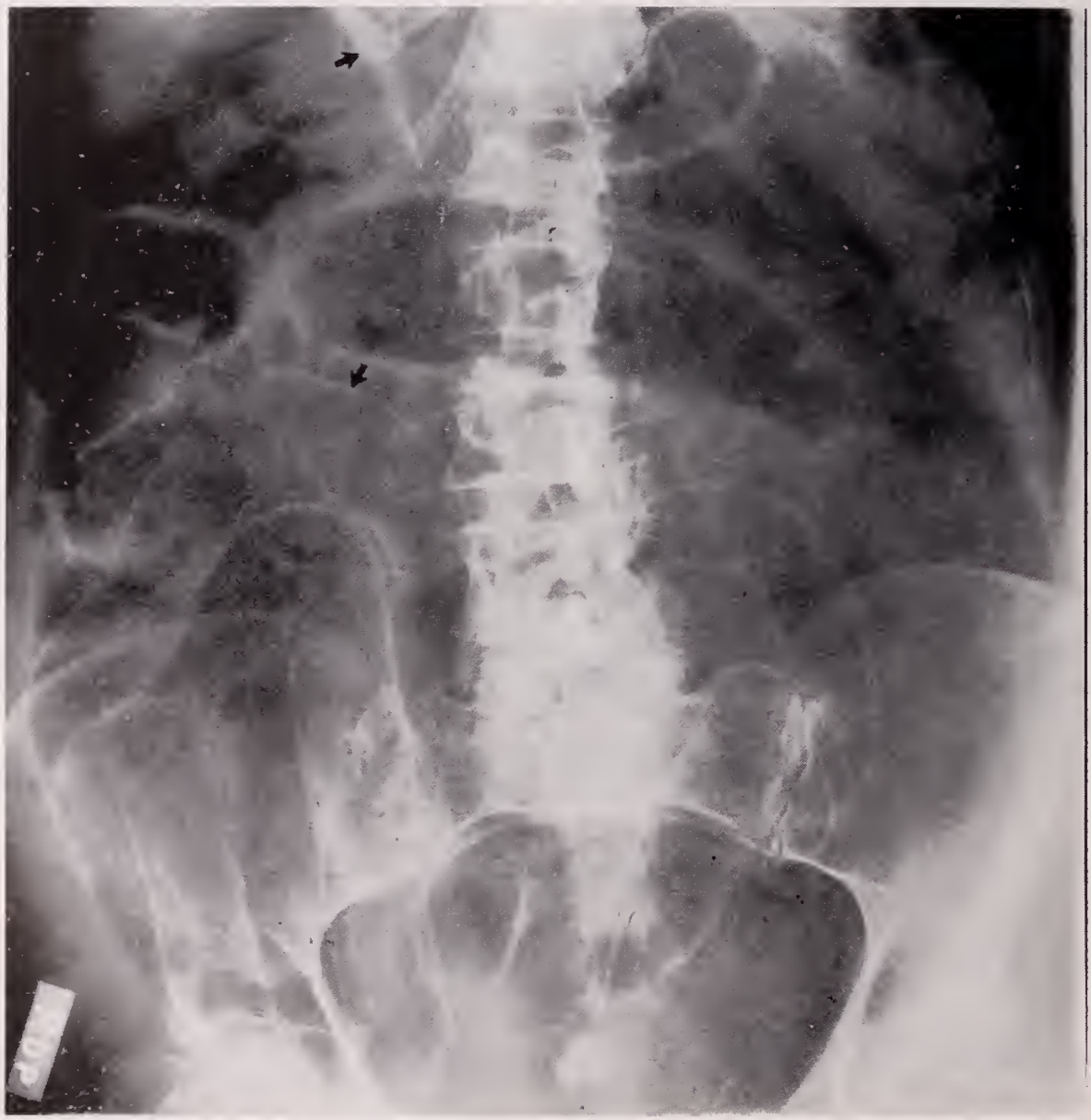

Figure 1-A. A supine view of the abdomen showing a pneumoperitoneum. Upper arrow points to the falciform ligament. Lower arrow shows outer margin of the bowel wall. Intraperitoneal air is also extending out to both flank margins. Patient had perforated colon secondary to ulcerative colitis.

Figure 1-B. Enlarged view showing detail of the falciform ligament and visualization of both the inner and outer bowel wall margins.

tient is a large individual. Finally, the technical factors for proper exposure of a chest film allow greater contrast for easier detection of small increments of air.

Thus, the proper procedure for demonstrating small amounts of intraperitoneal air as described by Miller[2] and Nelson[1] with minor modifications is as follows:

(1) Place the patient in a left lateral decubitus position (left side down, right side up) for 10 to 20 minutes, preferably 20.

(2) Expose the left lateral decubitus film. (Fig. 3-A).

(3) Place the patient in an upright frontal position and expose the anterior-posterior chest roentgenogram. (A standard 90° tilting radiographic table with a foot stand can be used for all of the views).

(4) While the patient is in this upright position, expose the anterior-posterior abdominal film.

(5) Finally, place the patient in a su-

Figure 2. A supine view of the abdomen showing a pneumoperitoneum from perforation of a gastric ulcer in an adult male. The falciform ligament and the outer margin of the bowel wall are clearly seen.

pine position and expose the supine abdominal roentgenogram.

The left lateral decubitus position is utilized because the most common types of perforation are to the right or near the midline.[1] Air will then rise into the right flank and be contrasted between the right abdominal wall and right lobe of the liver (Fig. 3-B). As the patient is moved into the upright position for the chest exposure, the air will rise from the right flank and locate under the right hemidiaphragm. Extra-alimentary air is best seen in this position and appears as a lucent crescent between the densities of the right hemidiaphragm and the right lobe of the liver (Fig. 4). This position change must be performed carefully, otherwise air might escape to the left subdiaphragmatic area where differentiation between air in the gastric fundus or colon may be difficult. It is best to maintain the left lateral decubitus position while moving the patient from the stretcher or hospital cart onto the radiographic table. We place the patient in a left lateral decubitus position on the stretcher in the emergency room. This position is maintained during the journey to the Radiology Department utilizing a portion of the mandatory 10 minute time.

The purpose of the upright and supine abdominal films is to detect any additional abnormalities, such as a bowel obstruction, that would have an effect on the immediate care of the patient.

Summary

A supine view of the abdomen is usually helpful in diagnosing a pneumoperitoneum in the adult only when large amounts of intraperitoneal air are present as from a perforated colon or stomach. A more accurate method of diagnosing pneumoperitoneum

Figure 3-A. Position for left lateral decubitus view of the abdomen. The horizontal beam is centered one or two inches above the iliac crest. The top of the 14" x 17" grid cassette is at the midaxillary line.

developed by Hodges, Miller, Freimanis, and Nelson is presented. If this procedure is followed meticulously, the diagnostic accuracy of pneumoperitoneum is definitely enhanced.

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Figure 3-B. Large pneumoperitoneum seen on a left lateral decubitus view of the abdomen. Note the air located between the right lobe of the liver and right upper abdominal wall.

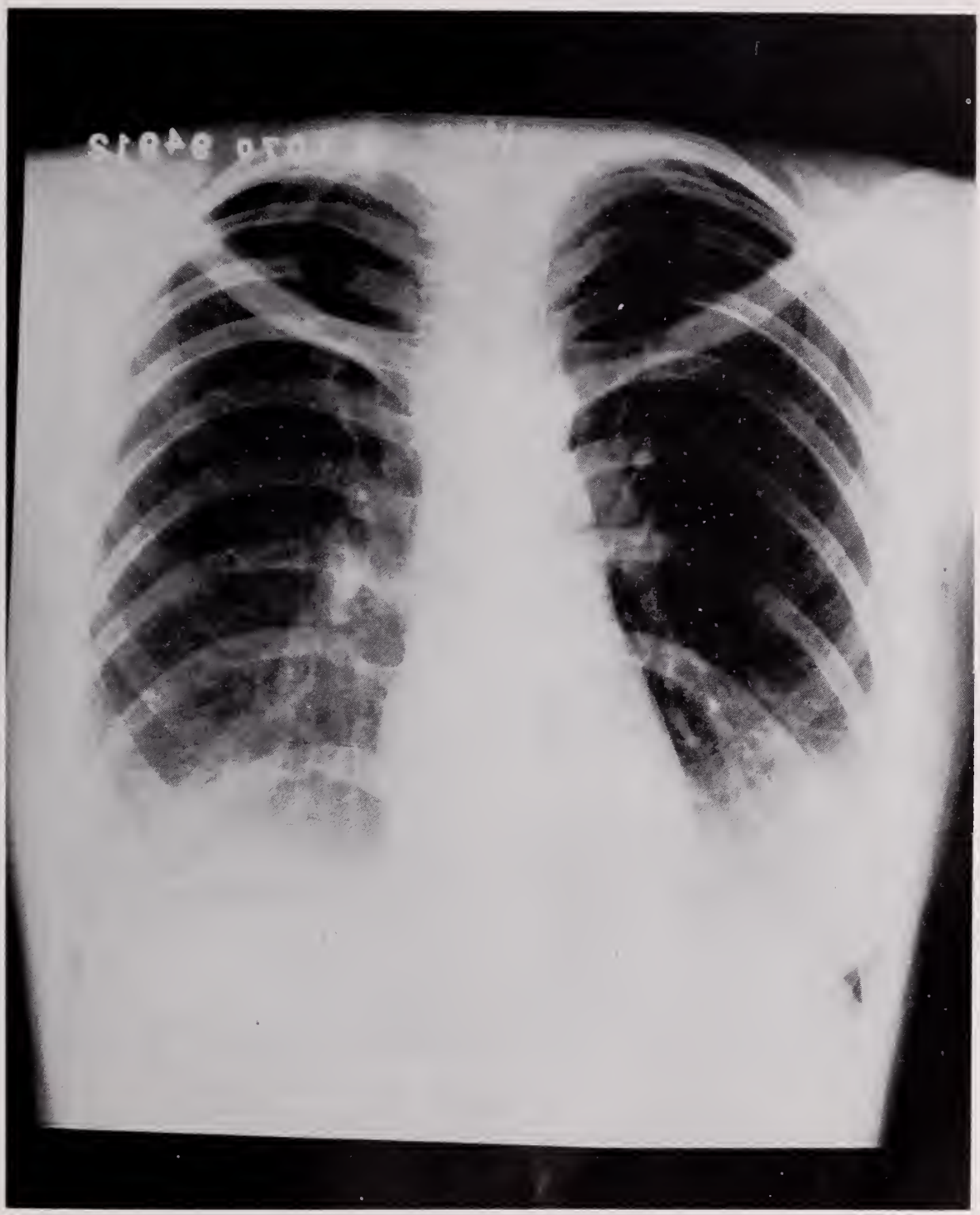

Figure 4. Upright view of the chest showing the lucent crescent of extra-alimentary air between the right hemidiaphragm and right lobe of the liver. This patient had a perforated duodenal ulcer.

Cancer Resistance: Part II*

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Cancer Variations in Families in a Normal Population†

Introduction

DESPITE world-wide interest in the epidemiology of cancer, the literature includes very little reliable data on the distribution of cancer in families derived from large numbers of consecutively ascertained normal subjects in the general population. We have attempted to elucidate this problem through pedigree and statistical studies of a large number of families ascertained through normal subjects.

Methods and Results

Family histories of cancer of all anatomic sites were evaluated in more than 4,000 consecutive persons who underwent either routine cancer screening examinations in a mobile multiphasic cancer detection unit (group I [Omaha], all ages considered, 3,261 patients) or were seen as part of a breast-milk study (group II [Detroit], involving women 45 years or younger, 1,058 patients), from which 2,044 maternal and paternal lineages were studied. These investigations were conducted independently at the two medical centers.

Results of these extended studies, based upon first degree relatives, showed that approximately 46 per cent of families were cancer free (Table 1). Only 7 per cent of families were predominantly cancer prone as shown by the occurrence of three or more first degree relatives with cancer. Figure 1 characterizes findings from the Omaha population comprising over 3,000 families.

Data with respect to breast cancer occurrences in groups I and II show that approximately 9.1 per cent of all families in group I have a single member with breast cancer, and 7.4 per cent of all families in group II have a single member with breast cancer. In both groups I and II, approximately 0.7 per cent of all families screened have two or more first degree relatives with breast cancer. Findings show that the ratio of single (sporadic) to multiple breast cancer is 13.0 to 1.0 in group I, and in group II the ratio is 10.6 to 1.0. When groups I and II are combined, the ratio of families with a single to those with multiple breast cancer is 11.8 to 1.0. These data characterize for the first time the relationship between sporadic breast cancer and familial breast cancer in a normal population. Studies are in progress which will provide similar data for all histologic varieties of cancer; in addition,

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Table 1

DISTRIBUTION OF PARTICIPANTS IN OMAHA AND DETROIT TO THE NUMBER OF CANCERS IN THE FAMILY

Category	Group I Participants Number	Group I Participants Percent	Group II Participants Number	Group II Participants Percent
No History of Cancer	1,520	46.6	470	46.6
History of a Single Cancer	1,082	33.2	296	29.3
History of Multiple Cancers	659	20.2	243	24.1
Total	3,261	100.0	1,009	100.0

familial associations between two or more malignant neoplasms will be evaluated.

Discussion

Cancer resistance may be determined on a multifactorial basis. Therefore, it is reasonable to ask the question, "Are families which show a remarkable freedom from cancer receiving this protection on the basis of multiple - gene transmitted constitutional characters?" Falconer[1] suggests that, when considering diseases which may fall into the category of multifactorial inheritance, one should consider together both genetic and environmental factors which make a particular individual more or less likely to develop a disease such as cancer or diabetes mellitus, and that these should be combined into a single measure which he refers to as the individual's "liability." He reasons that the "liabilities" (susceptibility) of individuals in a population form continuous variables and that the apparent discontinuities between "affected" and "normal" arise from "threshold" differences at some levels of the liabilities. Thus, individuals with liabilities above the threshold are affected, and individuals with liabilities below the threshold are not. The liability of any one individual cannot be measured with precision. On the other hand, however, mean liability may be evaluated for a population or group from the incidence of the disease in that population or group. Thus, liability can in principle be expressed in units on a scale that renders its distribution normal (i.e., fitting a Gaussian or normal curve), and measurements of the mean liability are the standard deviations on the scale.

According to Falconer[1] "The analysis provides an estimate of the correlation between

Figure 1

DISTRIBUTION OF POPULATION SCREENED IN THE MOBILE CANCER DETECTION UNIT ACCORDING TO THE NUMBER OF CANCERS IN THE FAMILY

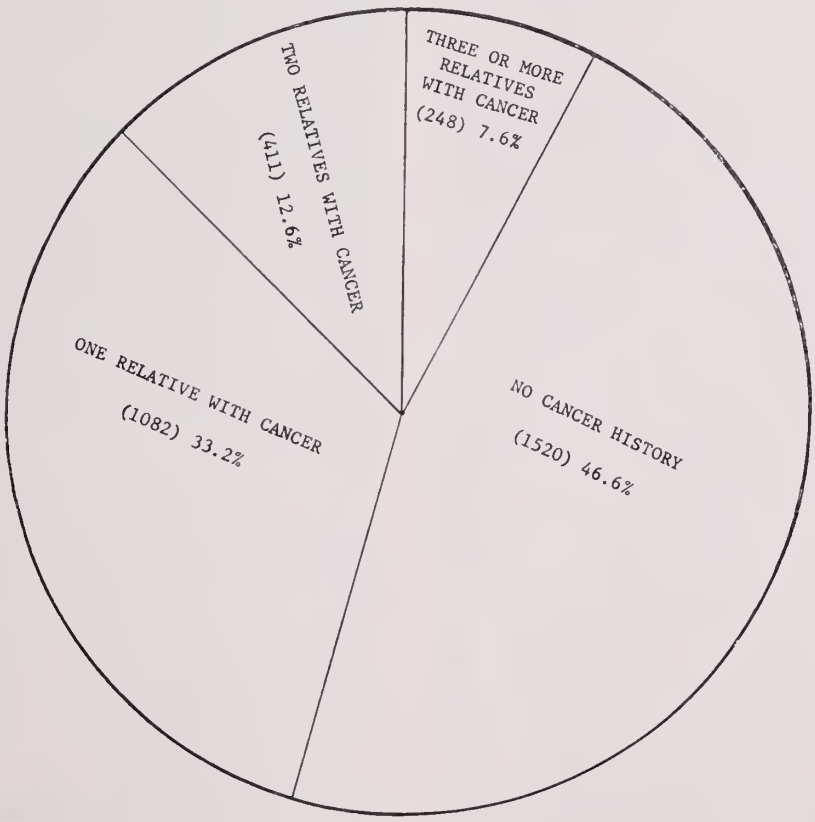

Figure 1. Distribution of Population Screened in the Mobile Cancer Detection Unit According to the Number of Cancers in the Family.

relatives in respect to liability, and this leads, with certain assumptions, to an estimate of the heritability of liability in the population. The heritability is the proportion of the variance of liability that is ascribable to additive genetic variance. This is the nearest to which one may approach, with human data, the degree of genetic determination of liability. The data required for the analysis are the incidence of the disease in the population and the incidence in relatives of affected propositi drawn from the population."

The liability or proneness to a disorder is a function of interacting environmental and genetic factors. These factors operate in differing orders of magnitude depending upon the individual's specific genetic and environmental circumstances. Thus, when environmental factors are more significant, the relative effects of hereditary factors will be less significant. Families like A and B (cancer-resistant, Part I) may be associated with environments which are not strikingly different from each other. These families, however, show different heritabilities of cancer predisposition and resistance.

A heritability determination is an estimate of the proportion of the total phenotypic variation (i.e., individual differences) that can be attributed to genetic variation in a single generation of some particular population under one set of environmental conditions. The heritability of cancer may be defined as the extent to which variation in individual risk of acquiring cancer is due to genetic differences. A disease will show a greater-than-zero heritability if two or more segregating genetic alleles, which manifest different effects upon predisposition and resistance to the disease, occur on at least one chromosomal locus. Such a trait may show different heritabilities in different populations which are characterized by genotypic and/or environmental differences, because the manifestations of any particular gene depend upon interactions between that gene and the overall genotype as well as with nongenetic or environmental variables. An individual's predisposition or resistance to a particular disease process depends upon that individual's genetic norm or range of reaction and the environmental factors interacting with this genotype. A genetic factor may be manifested only by appropriate genotype - environment combination. A gene's harmfulness or usefulness is determined by the bearer's environment. Thus, the genetic epidemiologist functions as an ecologist seeking significant correlations between a disorder and one or another variable from the great array of environmental influences. One's success in such research is related to the uniqueness of the variable and the directness of its effect, to the frequency of the disorder, and to the ease of diagnosing the disorder.

In families with the cancer family syndrome an autosomal dominant genetic factor has been postulated; but in Families A and B, it is not possible to delineate a simple Mendelian pattern of genetic transmission for an alleged cancer resistance. Of the few cancers that have developed in kindreds A and B, most can be accounted for on an environmental basis. On the other hand, tumors in the cancer-prone branches of the families with the cancer family syndrome indicate a meaningful pattern or association.

The available vital statistics in all of these families range from the early part of the nineteenth century to the present time. During the period before World War II, more persons died from infectious diseases, childbirth, etc., than at the present time. It is also relevant to consider the number who died or were killed during or after the major U.S. and foreign wars of the nineteenth and twentieth centuries. These conditions have all affected the longevity figures in the studied families.

For further testing of the above hypothesis, an analysis of cancer occurrences from the standpoint of families prone to the disease as well as families showing a paucity of malignant neoplasms is needed. Furthermore, additional analyses must be made of the particular varieties of cancer, given the known epidemiological factors relating to the specific malignant neoplasms. For example, smoking is associated with bronchogenic carcinoma; promiscuity, multiple matings, and

poor female hygiene, are associated with carcinoma of the uterine cervix, etc.[2]

The cancer epidemiologist must constantly scrutinize all possible hereditary and environmental factors which could be of etiologic importance in the development of cancer. Unfortunately, many studies have concerned themselves only with single carcinogenic factors. Very few attempts have been made to relate non-genetic factors to host factors, e.g., cigarette smoking and family history,[3] solar radiation and cancer inductin in patients with xeroderma pigmentosum.[4-6] Few studies have been specifically concerned with cancer resistance in humans.[7, 8]

The observations brought forth in this paper show a wide variation in tumor incidence among extended families. They also demonstrate marked variability in cancer distribution in families of *normal* individuals from the general population. Biological variations structure the expectation that such distributions might occur in many families. Marked variations in life span exist between different species and between individuals within a given species. Goldstein[9] stated that this phenomenon implicates genetic factors and suggested that an explanation for variations in the aging process resides "in genomes with either different genetic programs or specific rates of mutability." Since cancer is generally an age-related disease, it is consistent with Goldstein's hypothesis that certain genetic programs "turn on" in different individuals in our population and thus elicit different diseases which partly account for variations in life expectancy of those individuals. Untreated patients with such classically inherited disorders as familial polyposis coli (Mendelian autosomal dominant) show a marked reduction in longevity due to the development of adenocarinoma of the colon at a relatively early age as the result of an inherited cancer diathesis associated with disease. Xeroderma pigmentosum is another example of a hereditary disease (Mendelian autosomal recessive) which imposes a serious compromise on a patient's longevity.[5] Other families are prone to coronary artery disease, either through inheritance of lipid or other metabolic abnormalities and/or gene-transmitted differences for factors yet undetermined but which predispose to coronary artery disease. Such individuals are additional examples of persons whose longevity may be seriously compromised by gene-transmitted constitutional characteristics. It is reasonable to postulate that genetic differences play prominent roles in a family's cancer proneness as well as its cancer resistance. This observation does not exclude the role of nongenetic factors such as the interaction of an oncogenic virus in a genetically and immunologically susceptible host whose constitution favors the development of malignant neoplasms.

The genetic basis of a disease is a reflection of the genetic basis of health and that due to the interaction of the large number of relevant hereditary factors or genes and the large number of environmental factors which influence the liability of persons of any given constitution to the particular disease.[9] The first step in understanding the etiologic role of biological heredity is to realize that the genotype (i.e., total genetic material) of an individual, the chromosomal material derived from his parents, is a set of potentialities and not a set of already-formed or predetermined characteristics. The relative contributions of heredity and environment for a particular disease differ with different overall heredities (i.e., total genotypes) and with different environments.

The only unequivocally reliable approach to a nonexperimental system is deferment of any final determination of the relevant modes of genetic transmission until each responsible gene can be recognized. An alternative investigative approach involves comparative studies in members of high-risk versus those in low-risk or sporadic families.[10] Even if predisposition to a given disease in an individual may be associated with a simple Mendelian mode of genetic transmission, some cases would be sporadic due to occurrence of phenocopies (i.e., the apparently same disease, characteristically associated with a particular gene or group of genes, brought about as a manifestation of other genes), diagnostic errors, etc.

The demonstration of both the occur-

rence of sporadic cancers (as in Families A and B) and of familial cases (as in the cancer family syndrome) shows heterogeneity in data which were previously considered as if they were homogeneous. Such data even show that the risk in selected families is great enough to suggest a simple genetic hypothesis[11] for transmission of major differences in the predisposition to cancer. The data have not established that any particular genotype is either necessary or sufficient for development of cancer. They do show, however, that certain types of cancer are particularly liable to develop in genetically predisposed individuals. Whether or not the disease actually develops in a genetically predisposed individual, or at what age it develops, and details of its symptomatology and severity, are determined by interactions with environmental variables and other genes. The happenings of nature are characterized by probability laws, rather than by simple causality.[12] The cancer epidemiologist can define his best posits, but he never knows beforehand whether or not they will come true in any specific case.

Summary

We have attempted to show that certain families in the general population show a profound paucity of cancer as demonstrated in families A and B in Part I of these presentations on Cancer Resistance. Furthermore, we have demonstrated that a sizeable proportion of the normal population (approximately 46 per cent) show an absence of cancer amongst first degree relatives, while a minority of the population (approximately 7 per cent) are cancer prone, as evidenced by three or more occurrences of cancer in first degree relatives.

These findings have implications for research in carcinogenesis, in that it may be as important to know why certain members of the population are at *reduced* risk for cancer as it is to know why those in the population are remarkably *cancer prone.* Cancer control implications also exist in that an important risk factor to be considered in any cancer control program is family history. This even applies to other obvious risk factors such as cigarette smoking, wherein it is well known that family history of lung cancer significantly increases the likelihood of the cigarette smoker developing lung cancer.

Finally, these studies indicate a wide range of cancer susceptibility in humans, a phenomenon that is a function of both genetic and non-genetic factors, and which is very similar to findings observed at the infra-human level.

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Gas Infections: More Than a Textbook Entity

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PAUL E. HODGSON, M.D.†

PART II

Case Five. A 60 year old lady with diabetes mellitus and hyperlipidemia presented to University of Nebraska Hospital with an acute onset of aortoiliac occlusion. Bilateral femoral embolectomy and endarterectomy were carried out. The left leg remained cold and lifeless and at 48 hours postembolectomy she had a left above-knee amputation. She did well for the next two days until the onset of coldness and pallor in the right leg occurred. A femoral embolectomy failed to improve this situation and a right above-knee amputation was carried out.

Twenty-four hours following this operation, the patient developed fever, tachycardia, and mental confusion. Examination of the right leg stump showed separation of the incision edges, edema, and skin discoloration. Wound culture showed Clostridia, Bacteroides, and Streptococci.

Daily debridment and antibiotics did not halt the gangrenous process and it was necessary to perform a femoral disarticulation to halt the advance of this infection.

Comment

Severe vascular impairment and diabetes give rise to an "ideal" combination for the development of an anaerobic wound infection, especially of the mixed type as demonstrated in this case.

Case Six. This 60 year old man was a tractor operator who had a vague two week history of perineal discomfort. He presented to his family physician with cellulitis and gangrene which involved the perineum, scrotum, and lower anterior abdominal wall. Gas was present in the soft tissues on x-ray examination, and cultures revealed mixed anaerobes including Clostridium perfringens. Multiple incisions with the placement of penrose drains were carried out and he was sent to University of Nebraska Hospital. Operative examination showed an extensive gangrenous process with muscle necrosis and surrounding erythema, induration, and crepitus. The perianal area, especially the right ischiorectal space, showed the most severe changes. This led us to suspect that this case of "gas gangrene" was the end stage of a neglected perirectal abscess.

Pain was not an outstanding feature, and the patient's initial mental attitude was one of apathy and indifference.

Extensive debridment of necrotic tissue was carried out as well as massive antibiotics, parenteral fluids, blood, and hyperbaric oxygen therapy. A diverting colostomy was performed.

Daily trips to the operating room as well as the use of porcine heterograft dressings were employed. Eventually the granulating bed was covered with split thickness skin grafts and the patient went home.

Comment

This patient probably had an ischiorectal abscess, which represents an area of the body ideal for contamination and growth of anaerobic organisms.

In Duff's series[1] all patients with "gas gangrene" of the perineum had the origin

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of the infection in a neglected perianal abscess or fissure.

Discussion

"Gas gangrene" is a general term describing the severe portion of the spectrum of anaerobic wound infections. Classically, it refers only to the fulminating myonecrotic process caused by the clostridial group of microorganisms. However, other anaerobic bacteria can mimic this process and early differentiation of (1) clostridial myonecrosis; (2) anaerobic (clostridial) cellulitis; (3) streptococcal myositis; and (4) mixed anaerobic cellulitis on a clinical basis may be difficult. Early surgical exploration is necessary to determine the extent and severity of a gangrenous wound infection. In cases of the less aggressive anaerobes, exploration may in itself be curative.[7] The important concept concerning gas infections is that a variable clinical picture exists. This spectrum ranges from simple anaerobic bacterial wound contamination to the rapidly progressive and devastating process of clostridial myonecrosis. Close and frequent observation of the infected wound and the patient's response to treatment determines the course of surgical management.

Early differential diagnosis of gas-forming infections, and hence the choice of the appropriate treatment, may be very difficult. The following chart may be helpful (Table 2).[8]

Considerable overlap in the clinical picture of the types of "gas gangrene," regardless of etiology, is common.

There is no universally accepted classification of gas-forming infections. Hence this may account for conflicting reports of the efficacy of any given treatment.

Clostridial myonecrosis is the result of exotoxins rather than bacterial invasion.[9] However, most authorities agree that antibiotics should be started early, usually in the form of pencillin intravenously in massive doses. Other antibiotics may be indicated if one suspects a mixed infection. These agents will not reverse the effects of clostridial toxins, but will stop their production as the responsible bacteria are destroyed.

TABLE -2-

DIFFERENTIAL DIAGNOSIS OF ANAEROBIC WOUND INFECTIONS

	Anaerobic Cellulitis	Clostridial Myonecrosis	Streptococcal Myositis
Incubation Period, Hr.	72-96	6-72	72-96
Onset	Sudden	Sudden	Insidious
Wound Pain	Slight	Slight to severe	Moderate to severe
Temperature, °F	99-100 with proportional pulse	101-102 with disproportionately high pulse	101-104 with proportional pulse
Toxemia	Mild and late	Early and severe	Mild
Hypotension	Rare	Early	Late
Gas	Profuse	Moderate	Moderate
Serosanguineous discharge	Moderate	Profuse	Profuse
Jaundice (hemolysis)	Rare	Terminally	Rare
Pathology	Invasion of connective tissues without muscle invasion	Invasion of connective tissue and both viable and nonviable muscle	Invasion of connective tissue and nonviable muscle only

Adapted from: Principles of Surgery: by Seymour Schwartz. Copyright 1969 by McGraw-Hill, Inc. Used with permission of McGraw-Hill Book Company. Used with permission of author.

Hyperbaric oxygen has been advocated by many clinicians in the past ten years as a method of reducing toxemia, arresting the gangrenous spread, and redeeming tissue of questionable viability.[3, 10-12] While this modality of treatment appears to be a definite adjunct to conventional therapy, it would still appear that surgical debridment is the mainstay and influences the course of anaerobic infections more than any other single therapeutic entity.[4] Although benefits of hyperbaric oxygen therapy have been demonstrated, several questions remain unanswered: (1) Realizing the relatively low diffusing capacity of oxygen even at three atmospheres pressure, does it in fact penetrate the mass of necrotic tissue the anaerobes have invaded? This is an especially legitimate concern prior to surgical intervention when the overlying skin may be relatively intact. Recent work has shown that hyperbaric oxygen was only able to elevate the tissue oxygen tension of the superficial dermis when measured with microelectrodes.[6] (2) What effect does elevated oxygen tension have on the aerobic bacteria, i.e. Pseudomonas invasion? Does it in fact encourage their presence and growth as secondary invaders?

Gas gangrene antitoxin has been advocated by some and condemned by many. Most authorities appear to discourage its use.

We feel that the conflicting and sometimes confusing suggestions for treating "gas gangrene" can be overcome by an integrated diagnostic and therapeutic program. This is based on a given patient's response to a logical progression of therapy, regardless of the type of anaerobic infection that is present.

(1) Recognition of the "at risk" patient:
   a. diabetes mellitus
   b. steroid or immunosuppressives
   c. debilitating systemic disease
   d. gastrointestinal tract operations
   e. deep trauma, especially to the extremities with muscle involvement.
   f. inadequate surgical debridment or primary closure of the contaminated wound
   g. drug addiction
   h. severe peripheral vascular disease
   i. burns

(2) Awareness of the early signs of systemic toxicity secondary to anaerobic infections:
   a. may occur before wound shows diagnostic changes
   b. can occur within a few hours of operation or injury
   c. fever
   d. tachycardia
   e. increased local pain
   f. altered mental status

(3) Gram stain of any wound drainage

(4) X-ray examination of soft tissues for gas

(5) Surgical exploration of the wound:
   a. obtain tissue for histological examination
   b. obtain tissue for anaerobic culture

(6) Surgical debridment of all necrotic tissue present.

(7) Massive penicillin (20 million units per day).

(8) Intensive care and monitoring for hemolysis, massive fluid and electrolyte shifts, arrhythmias, and renal shutdown.

(9) If gangrene and/or gas are present on initial wound exploration and debridment, hyperbaric oxygen therapy should be considered *providing* it does not delay the previous sequence. Myringotomy should be done prior to its use.

(10) Daily examination of the wound will determine the future need for hyperbaric oxygen therapy and debridment.

Summary

"Gas gangrene" is a term without bacterial criteria for definition. It is caused

by a variety of anaerobic organisms and may have a highly variable clinical course. This entity occurs in the already hospitalized patient and not just in cases of accidental trauma. We have recently seen several cases emphasizing the spectrum of this disease. The literature is confusing as to the role of hyperbaric oxygen therapy and gas gangrene antitoxin in treatment.

Case reports and our suggestions for an integrated diagnostic - therapeutic program for "gas gangrene" are presented.

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Emergency Transportation of the Neonate*

PART II

Geographic and Demographic Problems in Nebraska

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The problems of population distribution in Nebraska are not unique in this country. The concentration of over 50% of the population in the extreme eastern portion of the state has obvious disadvantages with respect to the establishment of regional centers for the care of high risk infant. The location of the existing high risk infant centers in Lincoln, Omaha and Scottsbluff are a reflection of population distribution. The organization of any transport system must take this into consideration, and must be keyed to transport infants to the closest regional center that can handle the needs of the particular infant. This will frequently involve the need for medical judgment on the part of an individual never having seen the given patient, for it would be disadvantageous to the patient to transport the infant requiring cardiovascular surgery to an intermediate center which must in turn transport the infant later to a third care center equipped to provide all of the complex support systems necessary for successful cardiovascular surgery in the neonate.

While the state of Nebraska has a population distribution that is disadvantageous for regional medical care, there are several favorable factors to be considered. First and foremost, there is a superb interstate highway system crossing the entire state with ready access to a large percent of population of the state. Secondly, there are good arterial highways leading into the interstate system, and travel through hilly or mountainous terrain is not a major problem. Similarly, the geographic terrain imposes relatively few difficulties for air transport of infants. Landing strips for fixed winged

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vehicles are readily available in most communities of the state, and helicopter travel is possible.

The other major factor that needs to be considered in respect to geography and transportation of high risk infants are the climatic conditions in Nebraska. Weather plays a very important part in the decision concerning the type of transport vehicle to be utilized. Air transportation is highly dependent on reasonable weather, both for helicopter and airplane transport. On the other hand, access of highways and secondary roads is occasionally limited because of snow or other weather hazards. In particular, the utilization of the mobile hospital van available through the University of Nebraska is particularly difficult during high wind, for the van is relatively unstable in cross winds. Assuming that weather factors are favorable, at the present time the decision to employ ground transportation would be reserved for infants coming from hospitals in a radius of 100 miles from the referral center, possibly slightly more if the referring hospital were located immediately adjacent to I-80. On the other hand, for distances beyond 100 miles from the referral center, air transportation would clearly be advisable. From distances of 100 miles the round trip time required to mobilize the van, reach the referring hospital, stabilize the infant and return to the referral center in Omaha would be approximately five hours, for the top speed of the van is 50 miles per hour. However, the utilization of air transport must include an estimate of time required for the transportation of the infant from the referring hospital to airport and from airport facility to the referral hospital, often significant time factors. The availability of the helicopter facilities at either end of the trip in the future might diminish the time factor considerably for the transport of infants by helicopter.

Equipment Problems in Transporting High Risk Infants

The major equipment needed for transportation of high risk infants clearly must include an incubator with self-contained battery pack for power as well as an adaptor to use a generator source of current during transport. The incubator must be capable of maintaining adequate environmental temperature of the infant, even during periods of time in which the incubator must be opened for access to the infant. The incubator must provide ready visibility of the infant as well as ease of access to the infant without loss of oxygen concentration. Two commercially available units currently meet all demands, the Air Shields and Ohio Armstrong Transport Incubators.

The incubators must be equipped with a source of supplemental oxygen sufficient to last for the total duration of the anticipated trip of the infant, both for inhalation and for utilization with positive pressure ventilators. Small supplemental oxygen tanks on the incubator care are essential for maintaining oxygen environment of the infant during transport from the hospital nursery to the van and from the van to the referral center, but larger supplies of oxygen must be available in the transport van.

Some devices for provisions for positive pressure ventilatory assistance are essential. The most readily available devices are the infant anesthesia machines or self-expanding, manually operated resuscitator units such as the HOPE or Ambu resuscitators. These are sufficient for short term use, but become inconvenient for long term management of infants. A number of respirators are adaptable for use during transportation, including Byrd, Bennett, Arp respirators. The latter has the potential of providing positive pressure ventilation using a face mask or nasal plugs, which is of theoretical advantage for some infants, but is inadequate for ventilation of infants with severe impairment of lung compliance.

Other equipment necessary for transporting an infant include a kit containing all the essential items for performing umbilical arterial catheterization at the referring hospital, I.V. fluids, an infusion pump for maintaining continuous infusion of fluids en route, and a medication kit containing emergency drugs as well as sodium bicarbonate or THAM. The availability of electronic cardiac monitoring is highly desirable, particularly for air transport of infants where

the noise factor is such that auscultation of heart tones is virtually impossible. The availability of oxymetry for monitoring inspiratory oxygen concentration and the availability of blood gas determinations either at the referring hospital or in the mobile hospital van are important adjuncts to providing optimal care of the infant during prolonged periods of transportation.

The vehicle chosen for transportation of the high risk infant must provide sufficient space to contain all the equipment listed above. In general, one or two individuals accompany the infant during transportation — a physician and nurse or medical student, for maintenance of respiratory support at the present time is almost totally dependent on the availability of the additional person to assist with care during transportation. The Mobile Hospital Van currently utilized by the University of Nebraska was described in detail by Drs. Van Leeuwen and Bolam. Previous description of this unit has been published in the Nebraska Medical Journal. While the mobile hospital van provides adequate space and full pressure for the necessary life support systems, it does not contain equipment for blood gas determination nor does it contain a positive pressure respirator. The advantages of the current mobile hospital van are several. It is spacious, well-equipped and has two-way radio contact with the Nebraska Emergency Radio Network, which maintains radio contact with the emergency rooms of all hospitals in the metropolitan Omaha area. The major drawbacks of the current mobile hospital van are two: the relatively slow speed on the open highway and the very poor suspension system and susceptibility to excessive motion in cross winds. Drs. Van Leeuwen and Bolam commented on the frequent difficulty both drivers and physicians have encountered with motion sickness during transport of infants.

Air transport of infants currently utilizes planes operated by a private flying service in Omaha. The problems associated with utilization of airplanes for transporting high hisk infants include the fact that the vehicle must have a sufficiently large passenger compartment to accommodate all the necessary equipment and the two people accompanying the infant during transport. This requires a twin engine aircraft. The aircraft used in transporting infants around the state of Nebraska do not require pressurized cabins, for altitudes reached are not sufficient to significantly lower atmospheric oxygen concentration or produce problems from decreased atmospheric pressure.

The major problem associated with helicopters for air transportation of infants is the relatively limited range of the helicopter, approximately two hours. For example, transportation of infants from Grand Island to Omaha would require a refueling stop during the course of the trip. The problem with noise is even more accentuated in the helicopter, and the smoothness of ride in the helicopter leaves a great deal to be desired, according to several participants who had traveled in the helicopters. The Huey helicopters available currently are of sufficient size to accommodate all the necessary equipment for transporting the high risk infant. The major source of helicopters in the state currently is the Air National Guard with headquarters at Lincoln. The two disadvantages to utilizing this system are the time lag necessary to mobilize the helicopter crew and the fact that authorization for helicopter use currently is dependent upon a "last resort" philosophy of use.

Manpower

Dr. Van Leeuwen spoke to the group of his experiences in establishing the high risk infant transport service that is currently operational at the University of Nebraska Medical Center. For optimal use, transporting an infant requires the attendance of one or two individuals during the period of transport — a physician and an assistant, either a medical student or nurse. The transportation of a mildly ill infant may require only the accompaniment of a nurse, but frequently information to confirm this is not available to the physician at the referral center when the mobile hospital van is dispatched to pick up the patient. The time estimate for personnel in transporting the infant includes a 20 to 30 minute mobilization time after receipt of the call, the time

traveled from the University Medical Center to the referring hospital, a variable period of time at the referring hospital to stabilize the infant and prepare him for transportation, and time travel from referring hospital back to the newborn intensive care facility. For a local transportation within the Omaha Metropolitan Area this total of time involvement would be approximately sixty minutes. For travel to the point 100 miles from Omaha, the total time of personnel involved would be approximately five hours. In addition to the above man hours, one must include the time of the driver, currently one of the security guards of the University of Nebraska medical complex, and the time of nursing service personnel and maintenance people for cleaning and replenishing supplies of the mobile hospital van at the completion of a trip.

While the initial time demands on faculty and house staff at the University of Nebraska Medical Center was small with the infrequent trips to transport infants, during the past year approximately 200 trips have been made in the mobile hospital van or by air ambulance to transport infants. The burden for providing physician coverage for this number of trips has become an increasing problem. Currently the task is assigned to pediatric residents, with a senior medical student assistant. There is a strong need to provide a better system of professional manpower for assisting transporting a high risk infant, either utilizing physicians and nurses from the referring hospital whenever possible or for organizing a better system of physician manpower to assist in transporting infants through both university medical centers in Omaha.

Role of BCG Vaccine Among American Indians

Summary

It is clear that BCG vaccination is no longer an applicable preventive measure among American Indians. In the years prior to 1950, efficient BCG programs would have decreased tuberculosis incidence substantially among populations on reservations, but tuberculosis control programs initiated by the Indian Health Service concentrated on acute care, and thus BCG vaccination did not play a significant role in tuberculosis prevention. The controversy which surrounded BCG in the medical literature may have been partially responsible for its limited use in tuberculosis prevention on reservations. This has been costly to the American Indian.

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TUBERCULOSIS was carried to America during the height of its devastation among the poor of Europe. The American Indians had little resistance to the White Plague, and it inflicted heavy suffering upon the race. Tuberculosis followed the westward expansion and left no tribal group untouched. By 1908, tuberculosis mortality was estimated to be 790 deaths per 100,000.[1] In 1967, the age-adjusted tuberculosis mortality among American Indians and Alaskan natives was 23.9 per 100,000, 8 times the national level. This rate represents a 70% decrease since 1955 but reflects that the disease is still a visible problem.[2]

The BCG (bacillus of Calmette - Guerin) vaccine was developed for use against tuber-

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culosis in France during the 1920s. It has not had a large popularity in this country, however, and it has created an ongoing medical controversy spanning 30 years. Obviously, workers in the field of Indian health have a deep interest in this debate.

Policy on BCG in United States

The wide use of BCG outside the United States is often cited by proponents of domestic use of this vaccine. Rosenthal[3] and Mande[4] have argued the virtues of BCG on the grounds that over 500 million people have been vaccinated; and BCG vaccination is mandatory by statute in France, West Germany, Norway, Russia, Brazil, and Japan. In 1926, William Park began vaccinating with BCG in this country, in New York City. In 1933, Rosenthal[5] established a BCG laboratory at the University of Illinois, with assistance from the Pasteur Institute, and initiated 390 BCG projects in 47 states.

In 1947, the Public Health Service began a 7-year study of BCG in Georgia and the results indicated a 31% decrease in incidence of tuberculosis as a result of BCG use.[6] Other statistically sound studies showed a much higher rate of protection. A 75% decrease in tuberculosis among infants in Chicago was shown in a study by Rosenthal et al, begun in 1937;[7] an 80% decrease was shown in a study by Aronson et al[8] of 3,007 Indian children on eight reservations in 1935. In a 20-year study of adolescents, the British Medical Research Council found BCG vaccination to be 78.4% effective.[9]

Objections to use of BCG are numerous. In 1935, 72 infants died in Lubeck, Germany, after they were vaccinated with faulty vaccine.[10] Occasionally, mild reactions to vaccination occur. Since it was discovered that atypical mycobacterial infections produce a "naturally acquired" immunity, many argue that such indigenous infections further lessen the usefulness of BCG.[6] The most cogent arguments are found in the success of alternative preventive measures, such as routine tuberculin screening coupled with isoniazid therapy. Vaccination with BCG produces a positive reaction on subsequent tuberculin testing, thus limiting this effective preventive tool.

Policies concerning the indications for BCG vaccination were slow in developing. In 1949, the American Trudeau Society (Medical Section of the National Tuberculosis Association) spoke first. The following is taken from their statement on BCG:[11]

> In the light of present knowledge, vaccination of the following more vulnerable groups is recommended, provided they do not react to adequate tuberculin tests: 1. doctors, medical students, and nurses who are exposed to tuberculosis; 2. all hospital and laboratory personnel whose work exposes them to contact with the bacillus of tuberculosis; 3. individuals who are unavoidably exposed to infectious tuberculosis in the home; 4. patients and employees in mental hospitals, prisons, and other custodial institutions in whom the incidence of tuberculosis is known to be high; 5. children and certain adults considered to have inferior resistance and living in communities in which the tuberculosis mortality rate is unusually high.

After publication of this statement, a similar stand was taken by the US Public Health Service[12] and the American Medical Association.[13]

In 1966, the current policy was stated by the Public Health Service:[14]

> . . . BCG should be used for the uninfected person or small groups of uninfected people living in unavoidable contact with one or more uncontrolled infectious persons who cannot or will not obtain or accept supervised treatment.
>
> . . . Based on available data, there is no epidemiologic indication for the use of BCG on a group or community basis in the United States. In particular, BCG is not recommended for medical and paramedical personnel and students, or for employees and inmates of penal institutions . . .

BCG Use by the Indian Health Service

Vaccination of Indians with BCG was begun in 1935. J. D. Aronson inoculated

3,007 Indian children in the Southwest, the Dakotas, and Alaska in one of the earliest field studies in this country.[8] According to the tuberculosis control officer of the Center for Disease Control, BCG was used in the Aberdeen (SD) Indian Health Service (IHS) area during the period 1948 to 1951. Its use rested with individual physicians and no records exist to reflect the magnitude of use. A BCG campaign was conducted in Alaska between 1949 and 1951. The short shelf-life of the vaccine and limited transportation crippled the program. Fewer than 3,000 persons were vaccinated, and essentially no vaccination has occurred since 1953.[15, 16]

In 1952, Dr. F. T. Foard, Director of the Federal Bureau of Indian Affairs, IHS, reported[17] that, during 1950, 75% of the 31,000 children in reservation schools were vaccinated with BCG. Those not vaccinated were to be controls, in an attempt to evaluate the vaccine's efficacy. Foard also announced that a BCG vaccination campaign was initiated in 1952 for all Indian children delivered in IHS hospitals; however, the major thrust of the IHS continued to be acute care programs and isolation of active cases. Information regarding the extent and success of BCG vaccination during this period is obscure. In 1954 the US Public Health Service took control of the IHS, and records from this period are generally unavailable. The extent of the use of BCG by the IHS since that time is also difficult to ascertain. The IHS does not have an official BCG policy but seems to follow the Public Health Service recommendations.

According to the Phoenix IHS area tuberculosis control officer of the Center for Disease Control, BCG vaccination is now limited to the Navajo IHS area. The tuberculosis control officer of that area reported that BCG use was discontinued in the early 1960s except in the Gallop (NM) IHS hospital, where approximately 25% of the 850 infants born annually are inoculated.

Because IHS policy is not clear-cut, it is not surprising that a number of workers contend that BCG should be used more extensively on reservations. This opinion acknowledges the visible tuberculosis problem among the American Indians and seems to be a rational challenge to the Public Health Service policy on BCG use. The basic question is the applicability of BCG vaccination as a preventive measure in a given population. Such a consideration must weigh the benefits of all alternative preventive measures against the logistics of deployment for each one. Springett[18] has devised statistical criteria for determining the applicability of BCG vaccination in a given population based on a study of BCG programs throughout the world. Tuberculosis among the Navajo and native Alaskan populations has been adequately studied to provide a useful model for understanding the problem.

The Navajo, the largest tribe in America, includes over 100,000 members. In 1955 the Cornell School of Medicine thoroughly studied tuberculosis on the Navajo reservation. At that time the incidence of tuberculosis among adults was significant; however, plans for a BCG vaccination program among school-age children were abandoned because of the low tuberculin conversion rate.[19] In 1969, the tuberculin conversion rate was 4/1,000 per year, based on the testing of 24,000 school children. This is significantly higher than the national average, 0.5/1,000; however, it falls far below the 1% per year which Sringett established as a minimum for BCG usefulness. The Navajo are classified in Springett's type II populations, in which the incidence of tuberculosis is decreasing from previously high levels. Among the Navajo, 80% of the active tuberculosis comes from the 25% of the population more than 30 years old.[20] It can be assumed that most active cases probably represent reinfection tuberculosis; for the Navajo, BCG vaccination would not produce appreciable improvement.

In the period prior to World War II, tuberculosis mortality in Alaska (concentrated primarily among the native inhabitants) reached more than 750/100,000. Nowhere else in North America was the problem this severe. The mortality has decreased precipitously from 650/100,000 in 1950 to no deaths in 1970.[15] This improve-

ment reflects improving standards of living and improved tuberculosis control measures based on tuberculin screening and isoniazid prophylaxis. In 1950, 90% of the children in western Alaska were tuberculin-positive by 6 years of age; in 1970, only 2% were positive.[16] A study of tuberculosis in Alaska by Kaplan, Fraser, and Comstock[15] analyzed the decreasing incidence rate as follows:

> Thus, using children less than three years of age as indicators of current average annual infection rates, these rates were estimated to be 25 per cent for the period 1949 to 1951, 8 per cent for 1957, 1 per cent for 1960, less than 1 per cent in 1963 to 1964, and zero in the present study.

From this information it is clear that the native Alaskan is a type II population for which BCG is not indicated.

Acknowledgment

We thank Drs. Harold Cole, Michael Cymamon, and Edward Pesanti, Center for Disease Control area tuberculosis control officers for Aberdeen (SD), Phoenix (AZ), and the Navajo Reservation, respectively.

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Radiology Case of the Month

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THIS ten year old white male was admitted to the hospital with a two-day history of mild, generalized abdominal pain which at the time of admission became localized to the right lower quadrant. Physical examination showed a pulse of 120 per minute, blood pressure of 130/95 and a temperature of 38° Centigrade. Tenderness and involuntary muscle guarding were present in the right lower abdominal quadrant. The leukocyte count was 12,200 with 70 percent neutrophils. Urinalysis was normal. Supine and upright roentgenograms of the abdomen taken at the time of admission are shown in Figure one, A and B.

Figure 1-A

Figure 1-B

THE MOST LIKELY DIAGNOSIS IS:

1. Regional enteritis
2. Right ureteral calculus
3. Acute appendicitis
4. Incomplete small bowel obstruction
5. Gastroenteritis

Differential diagnosis includes right ureteral calculi, mesenteric nodes, bone islands and phleboliths. Intravenous urography with oblique views will usually correctly localize a ureteral calculus. Mesenteric nodes are quite mobile and bone islands, of course, remain stationery on decubitus and lateral views of the abdomen. Unusual differential problems include opaque oral medication, gallstones, calcified appendices epiploicae and dermoid cysts of the ovary.

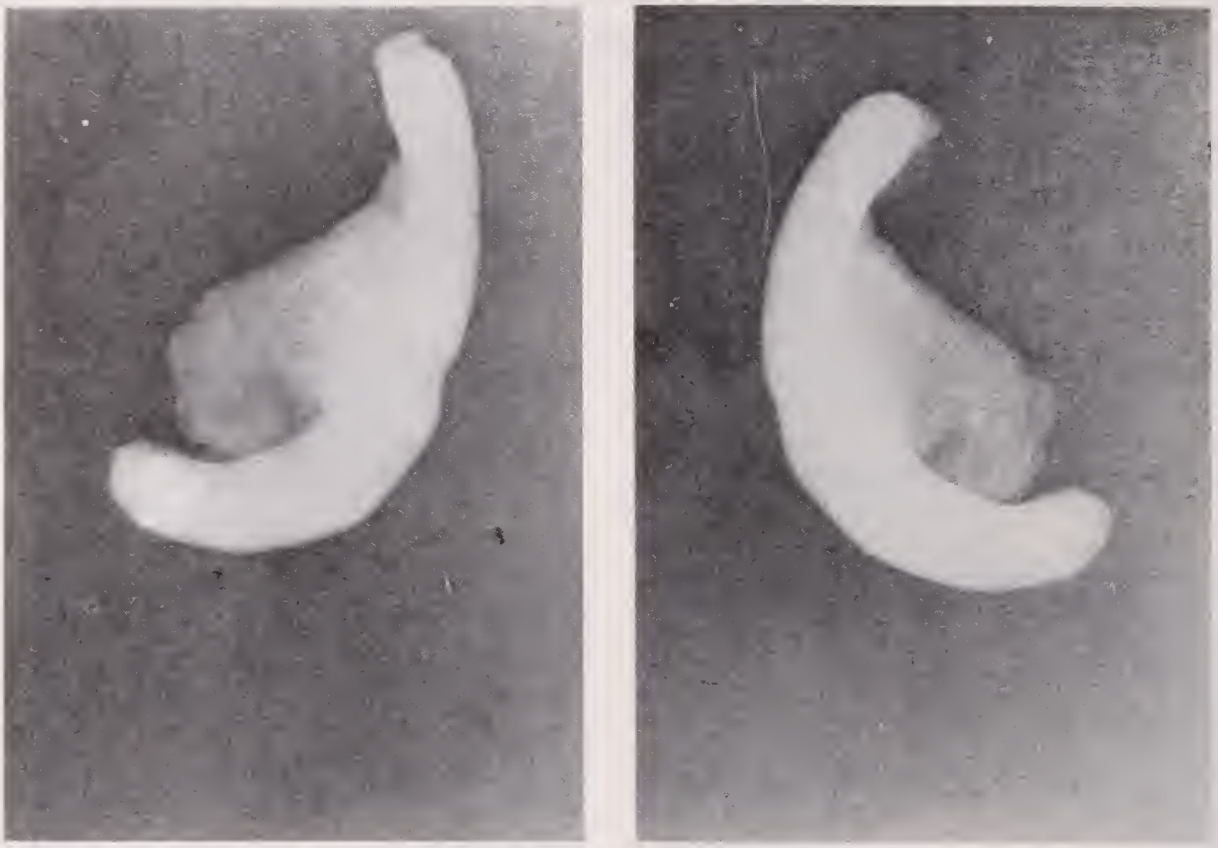

Figure 2

ANSWER:

Acute appendicitis with a calcified appendicolith. Figure 2 shows the resected specimen.

The supine and upright roentgenograms of the abdomen show a calcific density within the right lower abdominal quadrant. Dilated loops of distal ileum with air fluid levels are also present. The finding of localized air filled small bowel loops indicates atony secondary to an adjacent inflammatory process and is not necessarily specific for acute appendicitis. However, the presence of an opaque appendicolith is a much more specific radiographic sign for acute inflammation of the appendix. Roentgenographic visualization of appendicoliths have been reported in ten to fifteen per cent of appendicitis cases.[4] Identification of an appendicolith in a patient with abdominal pain indicates at least a ninety per cent chance of acute appendicitis being present.[2] In fifty per cent of these cases, perforation or the onset of gangrene has already occurred.[4] According to Stiles, when an appendicolith is found by radiographic examination of a child with abdominal pain, and other abnormalities have been excluded, immediately surgery should be performed.[7] In the case of an asymptomatic patient in which an appendicolith is present the indication for surgery is not as clearly defined. Brady and Carroll however, report several cases in which the chance finding of an appendicolith was followed by acute appendicitis within several weeks to two years.[2]

According to Fagenburg,[4] appendicoliths most commonly originate from the inspissation of fecal material. The inspissated nidus causes irritation of mucus glands which secrete a mucus rich in calcium phosphate over the fecal nucleus. When the resultant concretion reaches a critical size, pressure atrophy of the mucus glands stops the process. Obstruction of the appendiceal lumen results and the additive effect of local irritation from the appendicolith gives rise to inflammation. The increased incidence of gangrene and perforation results from

the high intraluminal pressure distal to the obstruction.

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The Inauguration Address

Abraham Lincoln in his first Inaugural Address delivered March 4, 1861, said, "It is safe to assert that no government proper ever had a provision in its own organic law for its own termination."

The five score and thirteen years which have passed since that time have done nothing to dispell the truth of that assertion. The proliferation of government with its regulations seems inexorable.

Doctors, fellow citizens, much of my thoughts during the past twelve months have dealt with the government and PSRO, Professional Standards Review Organization, and with our headlong rush toward a regulated society. These thoughts have been trying to me, and I would like to share their current evolutionary status with you.

Historically, medicine in the United States has, by steps, come from a totally undisciplined profession to a large self disciplined body. We have come from an era of cultism and dogma, from diploma mills and ignorance, to an age of a seemingly endless array of wonder drugs, wonder operations and technical advances, and on to a future of unquestioned brightness. Our medical schools are evolving to meet the challenges of a kaleidoscopic transformation in student needs. We can thank the Flexner report of 1911 for its stimulus in initiating educational changes which, when followed to their logical conclusion, helped precipitate the ability to meet the needs of today. We can thank a host of medical researchers, teachers and clinicians for their dedication to scientific principle and discipline, both of thought and action, for the advancements and wonders of today.

Now, none of us within the profession can claim the distinction of satisfaction with the degree of self discipline which we have attained — discipline, for example, in continuing education and discipline in self policing. We can, none-the-less, take great pride in our degree of discipline, in our status, efforts and achievements. American medicine is second to no other profession or calling in these respects. We know, those of us in this room as well as our antagonists and protagonists throughout this land, that our achievements have been many and great. We have with our forefathers, built upon solid rock. We have built upon a solid scientific foundation, with a solid educational system, and with solid ethics, a medical record unsurpassed in the history of mankind. This we have done largely through liberty and a self regulatory system. We have preserved human dignity and confidences.

That system today is in grave jeopardy, jeopardy from many factors. It is too simplistic to blame the government and power hungry politicians alone. We, together with the entire world, seem headed with ever increasing speed toward a regulated society. The causes of this are enigmatic to us.

Winston Churchill in 1941 said, "The destiny of mankind is not decided by material computation. When great causes are on the move in the world, we learn that we are spirits, not animals, and that something is going on beyond space and time, which whether we like it or not, spells duty."

Ladies and gentlemen, I believe our duty is clear. There can be no doubt that the concept of the certainty of the ever increasing encroachment of a regulated society is valid. The question, then, is who are to write the regulations and be the regulators? Under whose authorship are we to function?

We in the profession must continue, as our history dictates, to be the authors of our own consciences, of our own educations, of our own judgements. If this means we must enter more fully into the government arena, then so be it. We cannot abrogate the responsibility for maintenance of quality medicine to a hireling. We must preserve the determination of our own destiny. We, you and I, both within the profession and where necessary with the government, must ban together to see that only the best laws are written and then at only such times as are necessary.

James Lane Allen in 1897 said, "By degrees the comforting light of what you may

actually do and be in an imperfect world will shine close to you and all around you more and more. It is this that will lead you, never to perfection, but always toward it."

We must not lose sight of the fact that perfection and the highest quality health care have best been served by free men in a free society working through selfless self discipline.

Abraham Lincoln on another occasion said, "If there ever could be a time for mere catch arguments, that time surely is not now. In times like the present, men should utter nothing for which they would not willingly be responsible through time and in eternity."

Fellow physicians, we must recognize that the momentum toward a regulated society is very real. We must interact with this movement to maintain to the greatest extent possible the preservation and integrity of our own and our children's destinies. It is for this reason that I am pleased to have the opportunity to be of some service to this Medical Society.

Thank you.

J. H. Dunlap, M.D.

The Specialist

THE UROLOGIST

The urologist is our plumber, and while we may have problems with our faucets and pipes when we are young, we have more when we get older. I have never understood why urologists were surgeons and neurologists are not, but now we have urologic surgeons and nephrologists.

If you have a renal colic, he is your best friend, and if the deteriorating of your body begins with the prostate, you must go to him. Prostates used to come out through the belly wall in a nightmarish scene in which the surgeon grimaced and squinted at the ceiling as he triumphantly came up with the bloody thing in his hand. Then he learned to go through the perineum, and finally came the transurethral. Women are luckier.

If you can't P,
See me.

If it's red,
You've bled. (If it's gory, hory).

Excretion is important, and the nephrons and tubules and urethra probably do more than the colon. So we need our urologic friend with his KUB and IVP and TUR, even if we don't know whether to say urogenital or genitourinary.

If it's green
Or if it's yellow
Or in between,
See this fellow.

Plumber or not, he has become scientific to the point where nobody understands him, but he keeps us alive and in bed at night. Yet we are a little afraid of him.

If I P blue,
I'll see you.
But not till I do.

—F.C.

Picture Gallery

Pictures taken at the Fifth Annual Rural Medical Day Program held April 17, 1974 at the University of Nebraska Medical Center.

While Making Rounds

Number One.

An ever-growing group of women in this country have decided that the number of children they will have will be:

One or none.

That Beats Just Regular.

"Rate and rhythm even and regular."

Madness On Madison Ave.

I will never buy anything advertised by that form of insanity on the TV, or psychosis on the tube, known as the singing commercial; *never, never.*

Department Of Liver Tests.

"The cited dermatological exam shows that the patient has a severe case of cirrhosis."

I don't think they mean liver spots.

Section On Proctoscopy.

Dictated: "to 10 cm."

Typed: "210 cm."

That's nearly 7 feet. It hurt me just to print it.

More Acronyms.

SHOTS: Statewide House Officer Training System.

CHIP: Comprehensive Health Insurance Program.

On Looking Into The Crystal Ball.

"Prognosis: fair, depending upon how the patient responds to his treatment."

Division Of Etiology.

"Arthritis; cause V.D., nonveneral."

Department Of Higher Learning.

"Diagnosis: epigastric tenderness.'

Dear Heart.

"Heart revealed regular rhythm without murmur; grade II/VI pansystolic murmur at the apex radiating to the base and axilla was heard."

Some murmurs are hard to hear.

Quote Unquote.

"Quacks are the greatest liars in the world except their patients."

Benjamin Franklin

Like The Gettysburg Address.

"Lives far from habitation."

Weight-Watching While Walking.

If you walk 20 miles, you will lose a pound. I walk 2 miles a day, so that I can expect to lose 180 pounds in 10 years, when I will achieve zero growth. Then I can give up walking, or I may have to.

That's What It Used To Mean.

Coccyx: cuckoo, whose bill it resembles.

Artery: containing air; the ancients thought so.

Words We Can Do Without.

Genteel, opt, surmise, subsume, continuum.

—F.C.

Woman's Auxiliary

Mr. Speaker, members of the House of Delegates, it has been an honor to serve as the President of the Auxiliary to the Nebraska Medical Association this past year. Last year when I accepted the role of president, I challenged auxiliary members TO KNOW, TO CARE, TO BE INVOLVED. I feel that there are many things we should *know* because we are *doctors'* wives. I feel there are many things we should care about *because* we are doctors' wives. I feel there are many things in the community in which we *must be involved* because we are doctors' wives.

The purpose of the state auxiliary is to support the county auxiliary with ideas and resources to be an effective group — not a "pink tea" organization. The women in the counties are the ones who make the impact for medicine. Cooperation with them is essential.

After attending several national meetings I became convinced that regional workshops rather than the traditional "county visit of the president" would be a more effective way to reach more doctor's wives personally and informally, while sharing a day of ideas and fellowship. I cannot say that the workshops were a smashing success. They were, in fact, more like a dull thud. Attendance was a disappointment. We were unable to use the planned workshop format at any of the three locations because the number was not sufficient. The workshop idea was new, the response, poor.

I sense a reluctance of Nebraska auxiliary members to respond to new ideas. They choose and promote the programs that have been the accepted programs for ten to twenty-five years — such as Gems, Health Career Days, Bloodmobile, Meals-on-wheels, and making money for AMA-ERF. The new priority programs as suggested by our national auxiliary that seem to be relevant to meeting the needs of today's living such as Problems of the Aging, Mental Health, Ecology, Nutrition, Child Abuse, and Legislation seem to be of little interest.

ARE YOU RELUCTANT TO HAVE YOUR WIVES INVOLVED IN THESE AREAS OF CONCERN? Or, do you regard auxiliary as strictly a social affair? Even today, I feel priorities by doctors' wives are made on the basis of what is important to her husband.

The exciting challenge of medical auxiliary today is that its programs are not static — that it is a responsive organization concerned with the health needs of people and communities. Since health needs of the community are your concern, your wives should share that concern. Perhaps never before have Americans been so aware of the importance of their own well being as now. Health Education seems to be a popular subject. Recently it came to my attention as a member of our YWCA's Advance Program Committee, that agencies desiring support from Community Chests are asked to fulfill service in a number of categories — one being health education. The suggested programs for various church women's groups include health care as a topic for discussion. If health care is going to be discussed, we should know what is being said. Better yet, we really should be involved in the ideas that are expressed. In the area of health education, I feel that the AMA membership slogan is appropriate — that of, Join Us, We Can Do More Together. Let us join you, we *Can* do more together.

In October, after Helen McGinnis and I had been in Chicago for the Conference for Presidents and Presidents-elect, we went to Hinsdale, Illinois, to see that Health Education Center. We came home with a clear image of the exciting possibilities for the Health Gallery here as a Health Education Center in Nebraska.

From our National Auxiliary for 1974-75 three of the six program extension committees are health education committees. The first, entitled Health Education is comparable in intent to your committee, Health Education in Schools and Colleges. In addition to this are committees on Family Health and Community Health. So, you see through

our national auxiliary we are being encouraged to assess the Health Education needs in our communities and be leaders or catalysts for health education and services — at all times with your approval, of course. Being realistic, we also need your encouragement and guidance.

The other three program committees set up through our National Auxiliary are Internation Health, Legislation, and AMA-ERF. The one area that every auxiliary in Nebraska does support is AMA-ERF. I believe that Irene Kelley has reported to you concerning this year's progress.

The support we get from the national auxiliary through conventions, conferences, workshops, officers, chairmen, publications, developed programs and educational materials, and the association with other state leaders is a tremendous inspiration. The cooperation of every county auxiliary is essential for Nebraska to really benefit from this leadership.

I want to thank you for the support the Nebraska Medical Association has given us this year. Your office staff, Bill Schellpeper, Ken Neff, Susan, and Pam have been invaluable to me. Whatever the need or request, those in the office have most kindly and graciously responded. That is much appreciated.

During the next year under the leadership of Mrs. Kenneth McGinnis, the auxiliary will be anticipating Nebraska Auxiliary's Golden Anniversary.

Mrs. Warren Bosley,
President, 1973-74

SPECIAL ARTICLE

Looking Back

W. C. KENNER, M.D.

LOOKING back over nearly fifty years of experiences in the practice of medicine, it is amazing to think of the changes that have occurred during that time. It is hard to realize that insulin had been discovered and put to use in treating diabetes mellitus just two years before my graduation from medical school and much of the finesse in using it has been developed since then. It is hard to believe that I practiced for many years without the sulphas, penicillin, or any of the other antibiotics. Pernicious anemia was treated principally with diet. Think of trying to get two and one half pounds of liver into these patients daily — preferably raw. It was not easy.

One disease which is nearly nonexistent now stands out clearly in my memories. Smallpox was considered to be nearly nonexistent at the time of my graduation in 1924. I had never seen a case of smallpox, due to good acceptance, generally, of smallpox vaccination by most communities. However, while I was on the contagious service during my internship at the Ancker Hospital in St. Paul Minnesota, an epidemic of smallpox developed in the Twin Cities. By the time the epidemic was under control, there had been several hundred cases, many of them severe. People stood in long lines at the City Health Department and at various hospitals waiting to be vaccinated. All hospital employees were required to be vaccinated. Those who did not have an immune reaction or a successful primary reaction were revaccinated in ten days. The orderly who took care of our intern quarters was one who was vaccinated several times without a reaction. About two weeks after his last unsuccessful vaccination he became acutely ill, and in the course of just a few days was admitted to my department with hemorrhagic smallpox. After suffering acutely for several days, he expired.

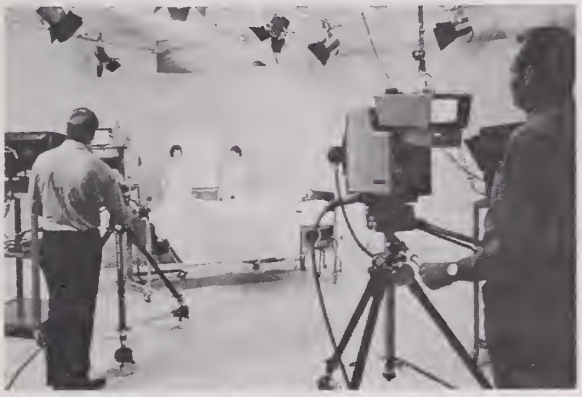
Losing a friend while you look on helplessly makes it very hard for me to believe that there is more hazard in a smallpox vaccination, properly administered at an early age when conditions are ideal, and repeated occasionally during the individual's life. I have given several thousand smallpox vaccinations in my office with only one reaction secere enough to require hospitalization. I fear that the present recommendation to discontinue routine smallpox vaccination has been made chiefly by individuals who have never seen a severe case of the disease. I hope and pray that they never do, but I would predict that if routine smallpox vaccination continues as a "No No" there will be a major outbreak of smallpox in the United States within the next twenty-five years — or about when the next generation reaches maturity. I hope that provisions have been made for adequate supplies of smallpox vaccine, which is not outdated, to be available at all times. Certainly the drug companies cannot be expected to do this at their own expense when its use is not advised except in special situations.

More pleasant subjects are plentiful. New surgical techniques and advances in medical treatment have continued to be developed regularly. Medical schools have been enlarged and greatly improved in technical facilities. The establishment of the Department of Family Practice in medical schools gives hope that more and more better trained physicians will be available for smaller communities. Young men entering practice have wonderful opportunities in many smaller communities. The close association of the Family Practice physician with his patients and their families gives him a great deal of personal satisfaction, as well as financial remuneration. One of my patients, whom I had recently delivered, surprised me when she said, "Doctor, do you realize that you have been the family physician for five generations of my family?" I was really astounded, but it was true. You really get to know families in that period of time. Multiply this or add to it many

second and third generation families and you realize you have had a rather important part in the development of your community. You cannot help but feel a little personal satisfaction as you watch well over three thousand of "your" babies as they develop through the usual and unusual childhood diseases, some becoming brilliant scholars or perhaps athletic stars, and then going on into the various fields of the business world.

Of course, you must ultimately come down to earth and always remember — "God and Mother Nature are wonderful."

Our Medical Schools



Creighton University's new television studio being used to video tape an instructional program.

New center at Creighton

Creighton University has a new Biomedical Communications Center. The new division is structured to provide audio-visual materials and methods and provide assistance to faculty who wish to utilize media in teaching, research, and patient care.

The Biomedical Communications Center serves all four Health Sciences. Departments within the division include: Closed Circuit Television, Graphic Arts, Photography, Classroom Services, and Utilization and Development.

The Closed Circuit Television Section provides TV service for instruction, research and patient care programming. Television studios are located at St. Joseph Hospital, and are a component of the Veterans Administration Network.

Another closed circuit television system is under construction at the Boyne School of Dental Science on the Creighton campus. Studios are equipped with special dental education equipment and remote self-contained cameras are located in laboratories.

The Graphic Arts Section provides artwork for visuals to be used in slide presentations, classes, or for public information. The Photography Section produces material used in classroom lectures, in publications, and in the illustrations of medical research.

The Classroom Services Section provides an equipment loan service and repair for audio-visual equipment used for educational and instructional purposes.

The Utilization and Development Section is involved in the use of all audio-visual services in creating programs that serve the needs of the faculty, students, staff, and patients.

To better serve the health needs of this area, Biomedical Communications at Creighton is developing a strong working relationship with the University of Nebraska Medical Center's Biomedical Communications division. Plans are under way to share teaching and continuing education materials.

The Creighton center is directed by Leon G. Benschoter, M.S. Benschoter formerly was coordinator of Instructional Television at the University of Nebraska at Omaha, and Assistant Manager of KYNE, Channel 26, UNO's educational station.

Hypertension grant

The University of Nebraska Medical Cen-

ter College of Medicine was awarded a $50,000 grant April 8 for heart research.

Physicians Mutual Insurance Company of Omaha made the presentation to Chancellor Robert D. Sparks at a noon luncheon at the Plaza Club.

The project will look for the best means of evaluating the risk of high blood pressure to individual patients and of predicting the most appropriate treatment for individuals. Community physicians throughout the state will cooperate in the study.

Award to Dr. Hartigan

A prominent Omaha physician, Dr. John D. Hartigan has received Creighton University's Alumni Merit Award. During ceremonies held in conjunction with the annual Alumni Merit Banquet Dr. Hartigan was presented a plaque and the following citation was read:

"Dr. John Hartigan is considered by his colleagues to be 'The Dean of Internal Medicine' throughout the midwest. Even though Dr. Hartigan was born and raised in Missouri he has lived most of his adult life in Omaha.

Dr. Hartigan's initial appointment to the Creighton School of Medicine came in 1947. In 1954 he was promoted to Assistant Professor of Medicine and elevated to Associate Clinical Professor in 1966. In 1971 Dr. Hartigan's faculty status was elevated to Clinical Professor of Medicine. He has held several offices in the Omaha-Douglas County Medical Society including the society's representative on the Omaha-Douglas County Board of Health. He has also served as President of the Board of Health and President of the local Medical Society. Dr. Hartigan was President of the Staff of Creighton Memorial Saint Joseph Hospital, and at Bergan Mercy Hospital he has served as Director of the Department of Medicine and Chief of Staff. He became Diplomate of the American Board of Internal Medicine in 1952 and was elected to Fellowship in the American College of Physicians in 1953. During the past four years he has served as Governor for the Nebraska Region of the American College of Physicians.

Dr. Hartigan has been recognized many times for his dedication and high ethical standards."

Heart disease grant to both schools

New research geared toward controlling and preventing heart disease and related disorders has been funded by Physicians Mutual Insurance Company of Omaha through a $100,000 grant to the medical schools of Creighton University and the University of Nebraska.

President F. T. Rahn of Physicians Mutual explained that although these goals were long ranged, the research being funded would "pave the way toward these objectives."

The grants will be divided equally between the two schools.

The Creighton University grant, $40,000 of which will be used for the study and application of some of the knowledge and technology acquired over the past few years to the detection and treatment of ventricular arrhythmias. Dr. Joseph M. Holthaus, Dean of Creighton University's School of Medicine, said in accepting the grant that this would be accomplished by wiring heart rhythm monitors to a computer and programming this to analyze each heartbeat.

Dr. Holthaus said that a number of com-

puter programs have been developed in recent years which have proved accurate in detecting and quantifying arrhythmias. "We believe our project would be a significant milestone in the treatment of this disease as we apply our findings to clinical practice."

Dr. Holthaus said that the remaining $10,000 of Creighton's grant will help finance research into the effect of estrogens in birth control pills on the cardiovascular systems of young women.

Nebraska Medical School will use a $50,000 grant for a study of high blood pressure in Nebraska through a data base of 65,000 hospitalized patients, including 9,000 suffering from hypertension.

In accepting the $50,000 grant for the Nebraska Medical School, Dr. Robert D. Sparks, chancellor, said that the objective of its research program would be aimed at reducing hospitalization time in cardiovascular disease, which currently "affects more than 22 million Americans and requires an average of nearly 11 days per patient for hospital evaluation."

Dr. Gatewood honored

A prominent Omaha physician, Dr. John W. Gatewood, was honored at a testimonial dinner held May 9 in the Grand Ballroom of the Hilton Hotel. Featured speaker for the evening was Mr. Frank P. Fogarty, Executive Director of the Nebraska Broadcasters Association. Dr. Arnold Lempka served as toastmaster.

Dr. Gatewood was recognized for exceptional service to Creighton University as a teacher and surgeon.

Dr. Gatewood is a member of the Alpha Sigma Nu National Jesuit Honor Society and Alpha Omega Alpha Honorary Society. He received the American Medical Association's Physicians Recognition Award in 1971, the Award of Merit from the Association of Operating Room Nurses of Omaha in 1972 and an Award of Merit from Childrens Memorial Hospital in 1973. He is a past president of the Omaha Clinical Club and the Omaha Douglas County Medical Society, past chairman of the American College of Surgeons Omaha Committee on Trauma, past chairman of the Nebraska Committee on Trauma, and former Chief of Surgery at Bergan Mercy Hospital.

Golden Apple awards

Six members of the Creighton University Medical School Faculty have been honored for their contributions to medical education. The six were presented "Golden Apple" awards at a banquet sponsored by the Creighton Medical Student Government. All recipients were chosen by medical students in secret balloting by individual classes. The awards presented were:

Freshman Class Award: Elsie Goodfellow, Ph.D.

Sophomore Class Award: Joseph Lynch, M.D.

Junior Class Award: Duane Sherwin, M.D.

Senior Class Award: Fred Pettid, M.D.

House Staff Award: Kent Teruya, M.D. (Voted by the Junior Class) and Maury Doerfler, M.D. (Voted by the Senior Class)

Contributed Service Faculty Award: Hugh Levin, M.D. (Voted by the Senior Class)

The "Golden Apple" awards are presented annually by the Creighton Medical School student body. Recipients receive a certificate and their name is engraved on a plaque that hangs in the Medical School.

President's Page

HOUSE OF DELEGATES — SPRING, 1974

Our State Medical Association House of Delegates does its job well. Multiple debatable issues, shortness of allowable time for discussion and for the researching of background material make the House's job more difficult. None-the-less, the delegates should take pride in their accomplishments.

For the most part, the delegates come to these meetings uninstructed by their constituents on the issues to be debated. Uninstructed, that is, on specific items, but in most cases quite fully instructed by having lived the same life as their constituents. This means "grass roots" representation in our policy making body.

At this most recent meeting in Omaha the problems and possible approaches to PSRO, the "hold harmless concept," state legislative matters, medical education, health planning, University student health, insurance, driver safety and a host of other problems and duties were met and dealt with in a competent, mature fashion to the credit of the profession and its individual members.

No one listening to these deliberations by men of similar backgrounds and educations can fail to be impressed with the sincerity and convictions of the speakers. Of more interest, though, is the multiplicity of viewpoints and insights brought to bear on the subjects. These divergent views are broadening, educational and often humbling.

Oh, yes, at times the viewpoints are tangential or in a different plane than the subject for discussion. At other times verbosity, narrow-mindness, sectionalism, mistakeness, parliamentary meanderings or even dumb-foolishness get in the way.

The physicians who have not had or taken the opportunity to take part in these proceedings have missed an opportunity for a contribution to their own betterment.

If our physician colleagues who have not been a part of our policy making body feel that the House (i.e. organized medicine) does a poor job or feel that "we have been sold-out" by the NMA, AMA or whatever, they are mistaken.

Perhaps the delegates could do a better job if they were entrusted with their constituents convictions and concerns prior to the meetings, instead of retrospectively.

Never-the-less, the delegates do a good job, and in good conscience!

J. H. Dunlap, M.D.

Down Memory Lane

1. Go into the offices of some of the men that a few years ago were a credit to our profession, and you will find them cluttered with machines of various types, each definitely guaranteed to accomplish the miraculous. They will tell you frankly that the other fellow is out to get the money, and that they too are going to get a share of it, and they will add that they are getting it.

2. I personally believe that the young men entering the field of surgery have far greater opportunities than the ones that have gone before.

3. There is a type of psychasthenic patient that leans on drugs, on appliances or members of his family, and on his physician.

4. The maternal mortality in the city of Omaha is decreasing. The maternal death rate per 1,000 births during the year 1923 was 6.7%. There were 4,874 births in Omaha in the year 1923. The total number of deaths in women of the child-bearing period, or from 15 to 47 years of age, was 355. The puerperal group was fourth on the list for causes of death in this group of women.

5. The annual meeting just held resulted in the addition of one new word to our vocabulary, if nothing else — "Cocktail-Duodenitis."

6. The Fifth Annual Post-Graduate Course for Practitioners will be held at the University Hospital under the auspices of the University of Nebraska, College of Medicine from June 16 to 28 inclusive. The fee will be $30.00.

7. National Hospital day, May 12, was generally observed at the hospitals throughout the state.

8. No private library can be adequate to meet the inspiration of the real student of medicine.

9. The Annual Meeting of the Nebraska Association of Medical Women was held at Omaha, Tuesday evening May 13.

Nebraska State Medical Journal
June, 1924

Necrology

By medicine life may be prolong'd
yet death
Will seize the doctor too.
—Shakespeare

Everett E. Angle, M.D., Lincoln 12- 2-73
Arthur C. Antony, M.D. (Life), Omaha 2- 4-74
Wesley C. Becker, M.D. (Life), Omaha 6- 5-73
F. Lowell Dunn, M.D. (Life), Omaha 5-16-73
Eugene G. Ewing, M.D., Madison 1- 2-74
Warren D. Hansen, M.D., Wisner 1- 1-74
Harlan S. Heim, M.D., Humboldt 3- 9-74
George Hoffmeister, M.D. (Life), Denver, Colo. 3-22-74
Randall Johnson, M.D., Omaha 6-11-73
Virgil S. McDonald, M.D., Poulsbo, Wash. 1- 2-74
Clarence Minnick, M.D. (Life), Cambridge 9-12-73
William C. Neihaus, M.D., Omaha 12-17-73
Charles A. Owens, Jr., M.D. (Life), Omaha 6-18-73
Carl H. L. Stehl, M.D., Lincoln 1-12-74
J. C. Waddell, M.D. (Life), Beatrice 7- 1-73
E. A. Watson, M.D. (Life), Grand Island 4- 2-73
V. Robert Watson, M.D., Seward 11- 3-73

Doctors James H. Dunlap, NMA President; Warren G. Bosley, NMA President-Elect; John D. Coe, NMA Immediate Past President.

NMA Sub-Committee on Athletic Injuries Chairman, John E. Murphy, M.D., presiding at the Tuesday Luncheon.

Doctor Warren G. Bosley addressing the House of Delegates.

Doctor Daniel G. Bohi moderating the Symposium on Gynecologic Cancer.

Doctors Warren G. Bosley and John D. Coe.

Doctor George B. Salter presenting the Necrology at the Opening Session.

Auxiliary President, Mrs. Warren G. Bosley, addressing the House of Delegates.

Doctor John D. Coe presiding at the Opening Session.

Doctor James D. Telfer speaking at the Tuesday Luncheon.

Doctor Roger D. Mason delivering the Invocation at the Opening Session.

WashingtoNotes

National health insurance

Triggered by the surprise introduction of a Kennedy-Mills proposal for national health insurance and a major effort by the Nixon Administration to get its own bill through this year, the Congress has again started a debate on the complex issues involved.

Appearing before the House Ways and Means Committee, Russell B. Roth, M.D., president of the AMA, warned that most of the congressional push for national health insurance (NHI) is based on the false premise that there is a health care crisis.

"The fact is," Dr. Roth told the Committee, "more people are receiving more and better medical care from more and better trained physicians in more and better equipped facilities than ever before in history.

"No doubt the Committee recalls a recent Harris poll, commissioned by a Senate subcommittee, which indicated that whereas 64 percent of the sample identified inflation as our nation's most serious problem, health care rated 15th, or next to last on the list, with only 3 percent of the respondents putting emphasis on this.

"We are convinced," Dr. Roth said, "that financial barriers to medical services are as real for middle income persons as for the poor — that there is great virtue in attention to ability to pay deductible and coinsurance amounts — and that our graded tax-credit approach is a superior feature in adjusting subsidies to needs.

Lashing out at the Kennedy-Mills NHI proposal, Dr. Roth said, "It is one thing to mandate the purchase of private insurance by employers. It is something quite different to institute increased payroll taxes, destroy the future of private insurance, and shift a well-regarded private function into a federal agency.

The financing envisioned in the Kennedy-Mills proposal gives us several problems:

"It creates a massive 4 percent increase in the Social Security tax. Wage earners will not be deluded by the fact that 3 percent is to be paid by employers and 1 percent by employees. The public is sophisticated enough to know that there is no free ride in this respect and the source of the funds to pay for such federal programs is from their compensation.

"We would point out further that under Social Security taxes, he who earns $20,000 a year pays the same as the person who earns 90 or 100 thousand. In our view, it would be more equitable for those who make more to pay more. We would prefer the sort of consistent sliding scale approach that is embodied in the Medicredit bill.

Health financing

The day before the AMA testimony before the Ways and Means Committee, HEW Secretary Caspar Weinberger told committee members that the Administration is serious about pushing for enactment of a NHI program this year.

Secretary Weinberger came down hard on the Kennedy-Mills proposal that would move toward the federalization of the nation's health care.

A major reason for prompt action, Weinberger said, is the prospect that "the American people appear to be in for a very rough period indeed as far as health care costs are concerned." Congress' failure to approve continued wage-price controls on health could lead to a $4 billion to $5 billion increase in health care costs next fiscal year and $9 billion the following year, he cautioned.

Though the cabinet secretary took swipes at all the major NHI competitors to CHIP, he reserved most of his fire for the Mills-Kennedy compromise. This bill calls for a Social Security NHI financed by a four percent tax and administered by Social Security as a virtually independent agency.

Mills-Kennedy, according to Weinberger,

"would take a major step down the road toward complete federal financing and control of all health care in the United States."

The Administration officer said Mills-Kennedy would impose $40 billion of new federal taxes "on top of a tax burden that many Americans already believe is excessive." Furthermore, Weinberger said, "payroll taxes are a much greater burden on the poor than is general revenue financing."

He said the Kennedy-Mills plan would virtually eliminate privately administered health insurance and substitute a fully federally financed and administered system.

PSRO

The government's procedures to assure that Professional Standards Review Organizations (PSROs) represent physicians in their local areas have been announced.

"In keeping with the PSRO legislation, we have developed procedures to assure that the organizations established as PSROs throughout the country are truly representative of the physicians in each of the PSRO areas," HEW Secretary Caspar Weinberger said. "It is the local physicians who will plan, operate and control the PSRO in each area, and, therefore, the organization designated as the PSRO must be their organization."

HEW, PSRO and the AMA

The government has labeled as "factually inaccurate and misleading" a kit on Professional Standards Review Organizations (PSROs) prepared by the AMA.

The HEW paper contends that the purpose of PSRO "was to give practicing physicians priority in undertaking the review of care provided rather than have the review performed by those outside the medical profession."

Contents of the kit, entitled "PSRO — DELETERIOUS EFFECTS," have been criticized by HEW and Senator Wallace Bennett (R., Utah), chief Congressional sponsor of the PSRO provision. The kit was prepared and distributed by the AMA at the behest of the AMA's House of Delegates to alert the medical profession to the dangers of such a review system.

Dr. Cooper appointed

Theodore Cooper, M.D., has been appointed deputy to Assistant HEW Secretary for Health, Charles Edwards, M.D. Dr. Cooper is director of the National Heart and Lung Institute. Henry Simmons, M.D., who has been serving as Dr. Edwards' right hand man, will continue to hold a deputy position but will concentrate henceforth most of his efforts at directing the Professional Standards Review Organization (PSRO) program.

VA names Dr. Chase

John Chase, M.D., a Veterans Administration career medical official for 22 years, has been appointed Chief VA Medical Director. Dr. Chase succeeds Marc Musser, M.D., who resigned.

NCME PROGRAMS

June 3 - June 16

GOOD TENNIS IS GOOD MEDICINE.

EMERGENCY TRANSVENOUS CARDIAC PACING.

SCANNING THE BRAIN IN CROSS SECTION.

June 17 - July 14

LICE, MITES, AND MAN.

ULTRASONIC IMAGING: ECHOES WITH ANSWERS.

LONG-TERM PACEMAKER THERAPY.

Coming Meetings

CRIPPLED CHILDREN'S CLINICS —
June 9 — Hastings, Elks Lodge
July 20 — Ogallala, Elks Lodge
July 27 — Chadron, Elks Lodge

SEMINAR ON ADVANCES IN PEDIATRICS — 14th Annual, at Childrens Memorial Hospital, Omaha, June 6, 7, and 8, 1974. The Seminar is jointly sponsored by the Hospital, Creighton University School of Medicine, and the University of Nebraska School of Medicine. Speakers will include: Dr. H. William Clatworthy, Ohio State University, Pediatric Surgery; Dr. George H. McCracken, Jr., University of Texas, Infectious Disease; Dr. Omar Burgert, Mayo Medical School, Hematology - Oncology; Dr. Joseph E. Ghory, Convalescent Childrens Hospital, Cincinnati, Ohio, Allergy; and faculty members of both local Medical Schools. The registration fee is $50 and includes continental breakfast and lunch. Write: Seminar Committee, Childrens Memorial Hospital, 44th and Dewey, Omaha, Nebraska 68105 for further information.

AMERICAN MEDICAL ASSOCIATION — Annual Convention, June 22-27, 1974, Palmer House — Palmer House Towers, Chicago, Illinois.

AMERICAN CANCER SOCIETY'S NATIONAL CONFERENCE ON GYNECOLOGIC CANCER; September 18-20, 1975, Marriott Hotel, Philadelphia, Pennsylvania.

AMERICAN CANCER SOCIETY — National Cancer Institute — Eighth National Cancer Conference; September 20-22, 1976, Regency Hyatt Hotel, Atlanta, Georgia.

NEBRASKA MEDICAL ASSOCIATION — Fall Session, October 3-5, 1974, Lincoln, Nebraska.

OMAHA MID-WEST CLINICAL SOCIETY — 42nd Annual Postgraduate Assembly, November 11, 12, and 13, 1974, Omaha Hilton Hotel. Write to: (Mrs.) Mary E. Pilloud, Executive Secretary, 1040 Medical Arts Building, Omaha, Nebraska 68102.

AMERICAN ASSOCIATION FOR CLINICAL IMMUNOLOGY AND ALLERGY — Annual Meeting; Pier 66, Ft. Lauderdale, Florida, November 21-24, 1974. Write to: John L. Dewey, M.D., P. O. Box 912, DTS, Omaha, Nebraska 68101.

AMERICAN CANCER SOCIETY — National Cancer Institute — National Conference on Advances in Cancer Management; Part I, Treatment and Rehabilitation, November 25-27, 1974, Waldorf-Astoria Hotel, New York City.

AMERICAN MEDICAL ASSOCIATION — 28th Clinical Convention, November 30-December 4, 1974, Portland, Oregon.

NEBRASKA MEDICAL ASSOCIATION — Annual Session, April 27-30, 1975, Lincoln, Nebraska.

AMERICAN CANCER SOCIETY — National Cancer Institute — National Conference on Advances in Cancer Management; Part II, Detection and Diagnosis, May 1-3, 1975, The Denver Hilton, Denver, Colorado.

Medicinews

New health planning bill

Representative Paul G. Rogers (D., Fla.), Chairman of the House Subcommittee on Public Health and Environment, has introduced HR 13995 the Health Policy Resources Development Act of 1974. Similar to an earlier bill, HR 12053, offered by Rogers, HR 13995 is a three-part bill providing for: (a) establishment of a National Council for Health Policy; (b) establishment of regional health areas and a Health Systems Agency for each; and (c) creation of State Health Planning Agencies. Unlike HR 12053, which is still awaiting hearings before the House Subcommittee, HR 13995 has no provision for federal loans and loan guarantees to assist in the construction of health facilities (resigned to replace the existing Hill-Burton program which is scheduled to expire June 30, 1974).

HR 13995 also differs from previous legislation, introduced in both the House and Senate, in that the State Health Commissions would not have rate-setting authority. While this is the first of the bills introduced to extend planning authority which does not give the state agencies rate making authority, the State Health Planning Agencies would have authority to: Certify which institutional health services are needed within the state; license health care facilities and health care delivery personnel in the state; set standards for health care facilities; and review for quality the performance of health services within the state. The State Health Planning Agencies would also have the responsibility to annually review and approve, or disapprove, the state plan submitted to the Secretary as a condition of entitlement to funds under this program, the Community Mental Health Centers Program, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

The local health systems agencies, which would be established under this bill, are similar to those proposed under previously introduced legislation and would be responsible for health planning for its health service area and for the development, within the area, of health services and facilities which meet identified needs, reduce documented inefficiencies, and implement the health plans of the agency. Other proposals, including some which may have no regulatory authority, are expected to be introduced before hearings are held.

Books

Handbook of Poisoning, by Robert H. Dreisbach; 8th edition; 517 pages; $6.50 limp cover; published 1974 by Lange Medical Publications, Los Altos, California.

Dr. Dreisbach is an M.D. and a Ph.D., and is Clinical Professor of Environmental Health, School of Public Health and Community Medicine, University of Washington, Seattle. This book appears to have appeared originally in 1955, so it is redone every 2 or 3 years, which testifies to its newness.

There are 36 chapters gathered into 6 sections. The type is fairly good, and there is a really good index. There are many tables, references, and an appendix. You can't beat the price.

F.C.

Books received

Emergency Medical Services, edited by John H. Noble, Jr., Ph.D.; Henry Wechsler, Ph.D.; Margaret E. LaMontagne, M.S.N., and Mary Anne Noble, D.N.Sc.; 595 pages; 15.5 by 23 cm (6 by 9 in); hardbound $24.95; published 1973 by Behavioral Publications, New York.

Emergency Medical Services Bibliography, edited by John H. Noble, Jr., Ph.D.; Henry Wechsler, Ph.D.; Margaret E. LaMontagne, M.S.N., and Mary Ann Noble, D.N.Sc.; 149 pages; 15.5 by 23 cm (6 by 9 in); hardbound $6.95; published 1974 by Behavioral Publications, New York.

Developments in Human Services, Volume 1; General Editors: Herbert C. Schulberg, Ph.D.; Frank Baker, Ph.D., and Sheldon R. Roen, Ph.D.; 536 pages; 14.5 by 21.5 cm (5¾ by 8½ in); hard cover $16.95; published 1973 by Behavioral Publications.

Community Psychology and Social Systems, by Stanley A. Murrell, Ph.D.; 287 pages; 14.5 by 21.5 cm (5¾ by 8½ in); hardbound $9.95; published 1973 by Behavioral Publications, New York.

The Letter Box

To the Editor:

LUNG CANCER PRONE FAMILIES

The medical genetics research team in the Department of Preventive Medicine at Creighton University School of Medicine has received funds for the study of Aryl Hydrocarbon Hydroxylase (AHH) in patients from families prone to lung cancer. The inducibility of AHH in lymphocytes has been shown to be a significant genetic marker in the study of 50 patients with lung cancer compared with appropriate controls by Kellerman and Shaw (New Eng J Med 289: 934, 1973). Needed are studies of close relatives from families prone to bronchogenic carcinoma. We believe that this study could harbor important information for carcinogenesis as well as for cancer control.

We will greatly appreciate receiving information about patients and/or their families wherein lung cancer apears to be increased in these families. AHH as well as pedigree verification will be performed and there will be absolutely no charge for any of these services. In addition, a detailed report of all findings will be forwarded to the concerned physicians at the completion of these studies. Your assistance in this study will be deeply appreciated by all of us.

Henry T. Lynch, M.D.,
Professor and Chairman,
Department of Preventive
Medicine and Public Health,
Creighton University School
of Medicine, Omaha, Nebr.

To the Editor:

Myasthenia gravis is a disease of the neuromuscular junction that is characterized by exacerbations and remissions, muscular weakness and fatigue that is often severe. It affects males and females of all ages, from the neonatal period to the eighth decade. Medically, the single most difficult problem is the recognition and diagnosis of the disease with some patients going undiagnosed for more than fifty years. Treatment of myasthenia gravis includes first establishing the diagnosis, the use of anticholinesterase medications, counselling, and in some select cases, the use of thymectomy and/or steroids, (Prednisone or ACTH).

Recently, the Nebraska Chapter of the Myasthenia Gravis Foundation was formed, with its headquarters located in Omaha. The objectives of this chapter include: (1) dissemination of information regarding myasthenia gravis to the medical profession as regards diagnosis, medical and surgical management, recent advances and pathophysiology; (2) Communication with those patients and families of patients that have myasthenia gravis, such that they may gain a better understanding of the disease, its treatment and the effects that it has on both the patient and their family.

For further information regarding myasthenia gravis or the Nebraska Chapter of the Myasthenia Gravis Foundation, please contact: Nebraska Chapter of the Myasthenia Gravis Foundation, 105 South 49th Street, Omaha, Nebraska 68132.

Sincerely yours,

Nebraska Chapter of the
Myasthenia Gravis Foundation, Inc.
Virginia Ann Calame, R.N.,
Chairperson
John F. Aita, M.D.
Medical Advisor

To the Editor:

The Maternal and Child Health Program of the University of California School of Public Health at Berkeley announces postgraduate courses of instruction for pediatricians, obstetricians, and other physicians interested in receiving training in the field of Maternal and Child Health. These programs all lead to the degree of Master of

Public Health. Tax-exempt Fellowships are available, consisting of support for the trainee and his dependents, tuition and fees.

Program areas at the present time include nine-month programs in Maternal and Child Health, Day Care and the Preschool Child, Health of School-Age Children and Youth, and Maternal Health and Family Planning. Twenty-one month programs in Care of Handicapped Children, Comprehensive Health Care and Perinatology are also available.

Applications are now being accepted for the group entering September, 1975. For information, write to Helen M. Wallace, M.D., School of Public Health, University of California, Berkeley, California 94720.

Sincerely,

Helen M. Wallace, M.D.
Professor and Chairman
Maternal and Child Health
Program

Dear Dr. Cole:

I enjoyed your editorial "What's Good for People" in the March issue of the Nebraska Medical Journal. I have recently sent a letter to a newspaper expressing another reason why drug brand names may be of benefit to the patient.

Sincerely,

Charles D. Barton

Bisalbuminemia in Stuttgart — H. Ott (Medizinische Klinik I, Burgerhospital, Stuttgart, West Germany) and B. Feinauer. Dtsch Med Wochenschr 98:1941-1946 (Oct 19) 1973.

The incidence of bisalbuminemia was found to be unusually high in Stuttgart and its surrounding region. In a long-term study carriers of the harmless trait were followed in 34 families over several years. In all the families the trait was inherited as a dominant. The relatively high incidence of the trait is explained by the relatively high mutagenic rate of albumin A and the low migration rate of people in the 18th and 19th centuries. In addition, transitory bisalbuminemia, behind which a new albumin allomorphism may be disguising itself, is apparently more common in the investigated areas. In 25 families investigated in detail, alloalbumin B predominated.

Long-Term Follow-up of Planned Treatment of Spontaneous Pneumothorax — I. Lichter (Dept of Surgery, Univ of Otago, Dunedin, New Zealand). Thorax 29:32-42 (Jan) 1974.

Ninety-six patients with spontaneous pneumothorax were treated initially by tube thoracostomy. Group A consisted of young fit subjects with disease confined to the apex of the lung; Group B was older subjects with overt, often widespread, pulmonary disease. In group A patients early resection was advised for those who had suffered a previous pneumothorax. In group B patients tube drainage frequently lasted up to 14 days. Failure of treatment by tube drainage was treated by excision of bullae in patients fit for thoracotomy, and by pleurodesis in the remainder. Managed in this manner, 95% of group A and 87% of group B patients were either cured or improved.

Coronary Bypass Grafting in 476 Patients Consecutively Operated On — J. E. Hutchinson III et al (St. Luke's Hosp Center, 421 W 113th St, New York 10025). Chest 64:706-710 (Dec) 1973.

The results of coronary bypass grafting procedures were reviewed in 476 patients consecutively operated on. The operative mortality was lowered from 7% in the first 100 patients to 0.8% in the remaining 376 patients. A comprehensive and detailed evaluation was performed by cardiologists in 122 patients operated on early in the series and followed for more than 18 months. Angina was totally relieved or improved in 89% of patients. Four patients out of 122 had sustained new myocardial infarctions during the follow-up period. Eighty-two percent of patients were able to return to employment.

Vitamin E in Angina — T. W. Anderson Dept of Epidemiology, School of Hygiene, Univ of Toronto, Toronto). Can Med Assoc J 110:401-408 (Feb 16) 1974.

The claim that the symptoms of angina pectoris can often be relieved by large doses of vitamin E was investigated in a randomized double-blind trial, in two parts. One part was conducted as a regular double-blind trial in which 20 patients received 3,200 international units of vitamin E daily, while an equal number received an indistinguishable placebo. After nine weeks, there was no statistically convincing evidence that the vitamin group had fared any better than the placebo group. The second part of the trial was also double-blind and involved 15 patients who were already taking a regular daily dose of 400 to 2,400 IU of vitamin E. Eight patients were assigned the same, or larger, dose of vitamin E, while seven received placebo. Over a period of nine weeks, anginal symptoms became worse in four of the seven patients receiving placebo, compared to no change in the vitamin E subjects, but this difference was not statistically significant.

Gold Salts in Treatment of Rheumatoid Arthritis — J. W. Sigler et al (Rheumatology Div, Henry Ford Hosp, Detroit 48202). Ann Intern Med 80:21-26 (Jan) 1974.

A two-year double-blind study was made of gold salt treatment in 27 patients who had active rheumatoid arthritis for less than five years. The gold salt (gold sodium thiomalate) was well tolerated in 13 of 15 patients. Improvement, measured by physical examination, ring sizes and grip strength, was noticeable in the treated group. Radiologic examination showed that the bone and cartilage destruction was arrested in several patients, and the mean progression rate of destruction was considerably slowed for the treated group.

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Physicians' Classified

FOR SALE, RENT OR OTHER AGREEABLE ARRANGEMENT — Medical office with active practice. South-central county seat town of 1500. New hospital and nursing homes. Three other physicians in county, only one is full-time, active. Contact: Box #46, Nebraska Medical Journal, 1902 First National Bank Building, Lincoln, Nebraska 68508.

GENERAL PRACTITIONERS NEEDED — County seat town, North-Central Nebraska. Clinic available across street from modern 34-bed hospital. Three nursing homes nearby, large trade area. Affiliation possible if desired. If interested, call or write Charles Sweet, M.D., 140 South 4th; Roy J. Smith, M.D., 732 West Fairview; or Administrator, Boone County Community Hospital, Albion, Nebraska 68620.

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CLINIC AVAILABLE — General practice in furnished clinic. County seat town, SW Nebraska. Three nursing homes in town, good territory. Equipped office available for dentist. Write Box 8, Beaver City, Nebraska 68926.

MEDICAL OFFICE FOR RENT OR LEASE — Cot-Nor Incorporated Suite 500 with 1,015 sq. feet located at 5440 South Street, Lincoln, Nebraska. Abundant parking available. If interested, contact Mr. Dick Gaughan, Manager of Cot-Nor Incorporated, Suite 1600, 5440 South Street, Lincoln, Nebraska 68506. Phone: (402) 489-2718.

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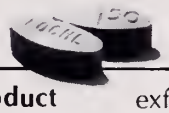

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species).

Note: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in chronic and recurrent urinary tract infections.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia in elderly patients on diuretics, primarily thiazides. Sore throat, fever, pallor or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. Data are insufficient to recommend use in infants and children under 12.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, allergy or bronchial asthma; and in those with glucose-6-phosphate dehydrogenase deficiency, where hemolysis may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12.

Usual adult dosage: Two tablets b.i.d. for 10 to 14 days. For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

Supplied: Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10.

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The Nebraska Medical Journal

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July, 1974

Everybody experiences psychic tension.

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Some people develop excessive psychic tension and need your counseling,

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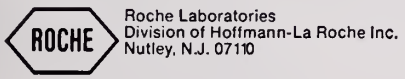
Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

You should be aware of the possibility of side effects in some patients and should consult the complete product information before prescribing.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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The Nebraska Medical Journal

EDITOR — FRANK COLE, M.D., 1845 "F" St., Apt. 1, Lincoln 68508
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The patient with asthma or allergy: another type for Tylenol® (acetaminophen)

When the allergic patient has a condition requiring an analgesic, a new problem arises. "Idiosyncrasy to salicylates is not rare and is usually manifested by skin rashes and anaphylactoid reaction. Sensitivity to these drugs occurs more frequently in patients with asthma and allergy."[1] Moreover, the previous ingestion of aspirin without ill effects is no guarantee that subsequent use will not precipitate a severe reaction.[2]

TYLENOL (acetaminophen), on the other hand, presents little risk of allergic reaction, even in patients sensitive to aspirin,[3] making it the preferred analgesic for the allergic patient.

This is only one of several 'types for TYLENOL'—that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Modell, W., ed.: Drugs of Choice 1970-1971, St. Louis, The C. V. Mosby Company, 1970, p. 196. **2.** Goodman, L. S., and Gilman, A., ed.: The Pharmacologic Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 327. **3.** Maslansky, L.: Paper delivered at Fourth International Congress of Allergology, New York, Oct. 18, 1961; abstracted Excerpta Med. Internat. Congress Series, No. 42, p. 124.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

Supplied: Tablets, 325 mg.
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ADVICE TO AUTHORS

The Editor of this Journal assumes no responsibility for opinions and claims expressed in the articles published herein.

Manuscripts to be presented for publication in the JOURNAL should be typewritten, double-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title-page should be shown the title of the article, the name (or names) of the author, his degree and other significant credits. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Illustrations should be numbered and their locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be in black (India ink) on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

Manuscripts (original, not a carbon) should be sent directly to the Editor at the Journal's address.

Letters to the Editor submitted for publication should be prepared as above, and must carry the notation: To be Published.

Reprints should be ordered from the printer, Norfolk Printing Co., Inc., P. O. Box 278, Norfolk, Nebr. 68701.

Our Medical Schools . . .

Eye grant to U of N

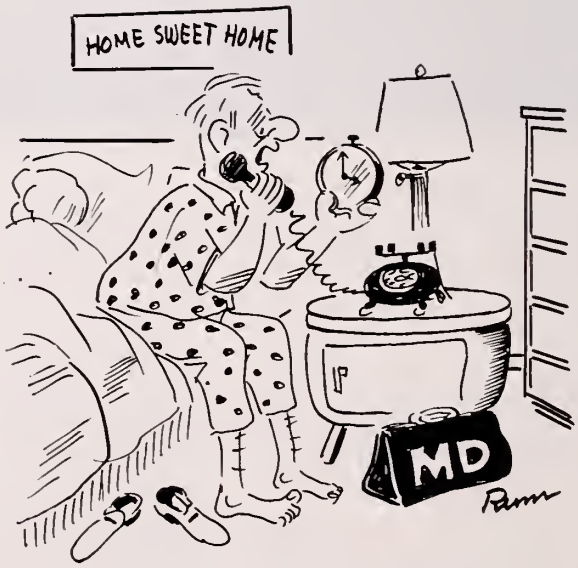
The University of Nebraska Medical Center's Department of Opthalmology has been awarded a federal grant for $86,000. The grant is from the National Eye Institute, one of the eight institutes of the National Institutes of Health.

The funds will be used for the acquisition of an argon laser and the establishment of a macular disease study clinic in the Department of Opthalmology.

U of N graduates

Forty-five graduates and one faculty member received special recognition at the commencement exercises of the University of Nebraska Medical Center Sunday, May 26, in the arena of the Omaha Civic Auditorium.

The recipient of the Distinguished Teacher award was Dr. James A. Davis, Jr., assistant professor of psychiatry. A faculty member for three years, Dr. Davis received both baccalaureate and doctor of medicine degrees from Nebraska. The Omaha native was selected for the honor by both faculty and students.



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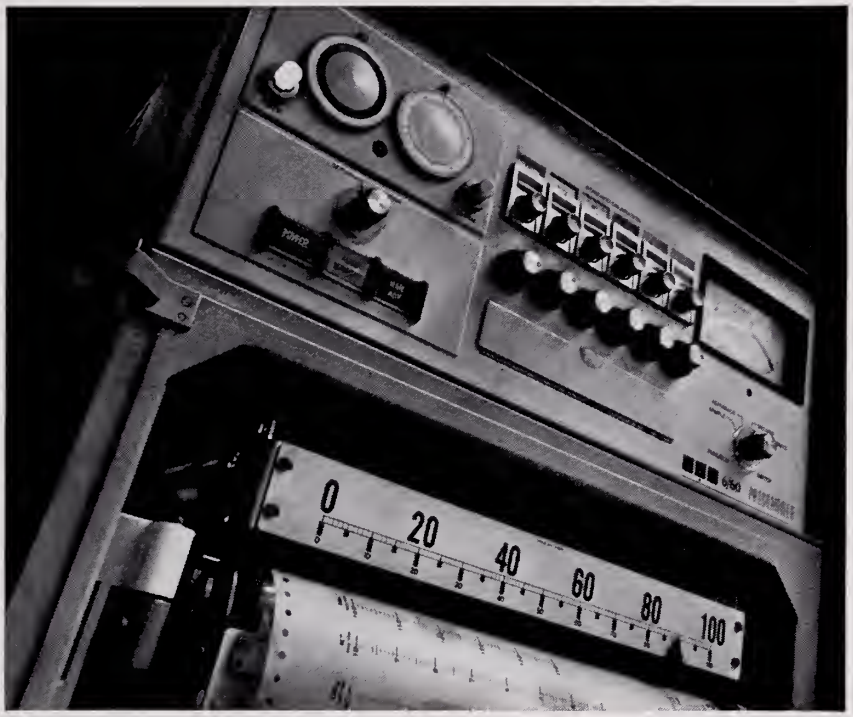

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Award to Dr. Herd

Dr. J. Kenneth Herd, associate professor of Pediatrics, Creighton University School of Medicine, has been awarded a $26,000 March of Dimes clinical research grant for one year. The announcement was made by Dr. Joseph Holthaus, Dean of Creighton Medical School, and Joseph F. Nee, President of the National Foundation-March of Dimes.

Dr. Herd will investigate enzyme treatment for Hurler syndrome and related diseases with the use of hyaluronidase.

Dr. Herd points out that hyaluronidase treatment is not enzyme replacement therapy since it is not the missing enzyme in Hurler syndrome or other diseases of mucopolysaccharides (MPS). His study is based on the assumption that hyaluronidase can non-specifically break down MPS and thus may be effective in all or most varieties of hereditary defects of MPS metabolism.

U of N graduates

As we go to press, the University of Nebraska Medical Center is to graduate 457 students — its largest class in history on May 26.

They include 139 doctors of medicine, one doctor of philosophy, four masters of science in medical sciences, six masters of science in nursing, 62 bachelors of science in pharmacy, 82 bachelors of science in nursing, 50 bachelors of science in medical technology, 16 bachelors of science in physical therapy, 18 bachelors of science in medicine, six bachelors of science in radiologic technology, 70 associates of science in nursing and three associates of science in radiologic technology.

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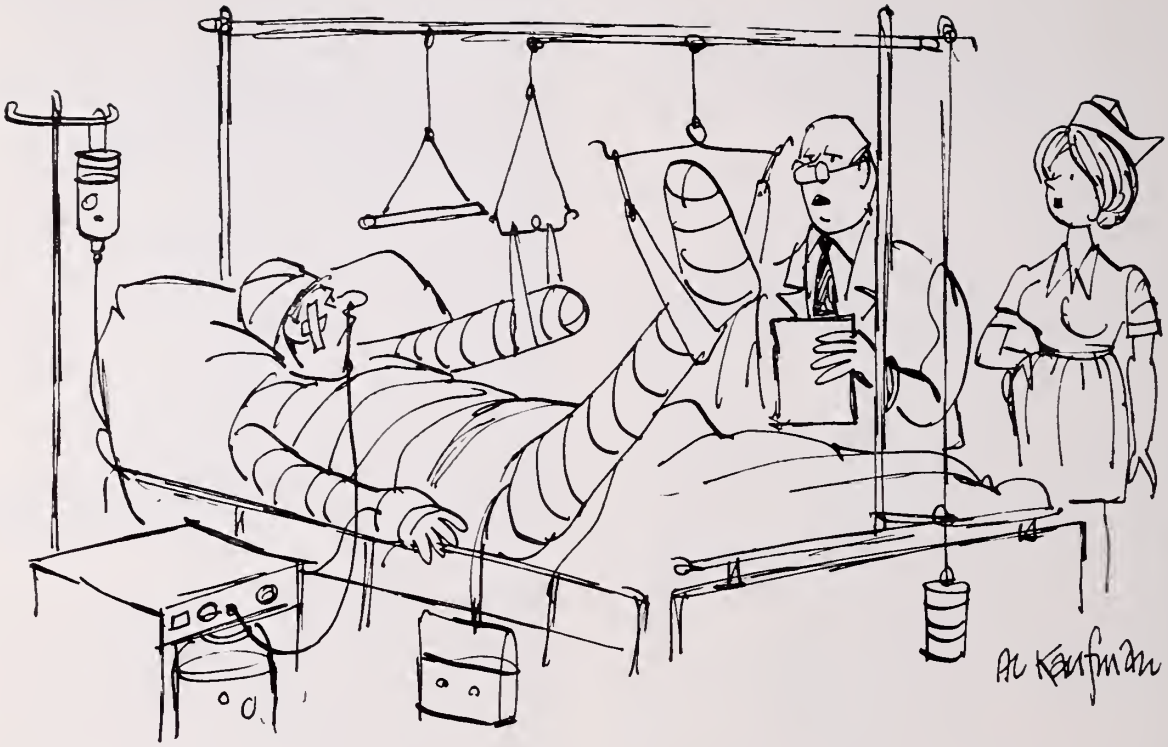

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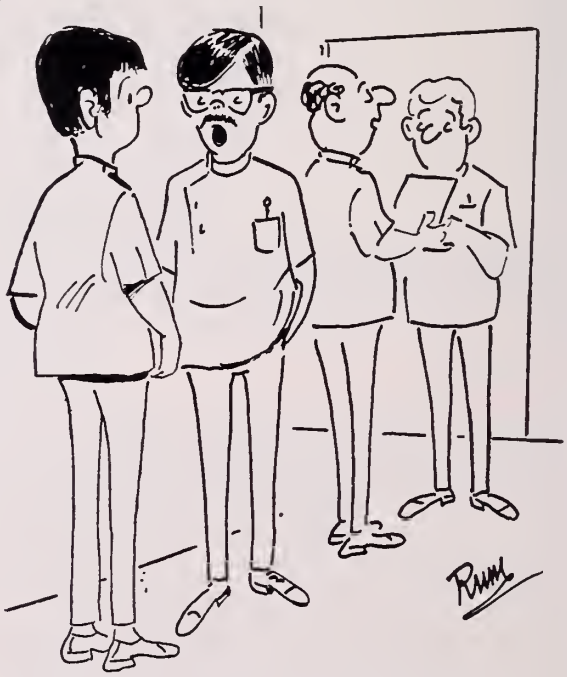
Hill-Burton

Also introduced this week was S. 3577, the Health Facilities Assistance Act of 1974, a three-year extension of the Hill-Burton program. The bill would authorize the Secretary of HEW to make grants, loans, and loan guarantees to public or private non-profit entities to assist in meeting costs for the construction or modernization of public or other nonprofit facilities, or the modernization of such facilities serving medically underserved populations. The bill would further authorize the establishment of separate accounts for each state and the annual allocation of funds to them. Allocations would be based upon population, financial need, and the necessity for construction and modernization in the respective states. Facilities receiving aid under the program would be required to assure that such facilities will be accessible to all persons residing or employed in the area. Recipient institutions would further be required to provide a reasonable volume of services to persons who are unable to pay. In determining this volume the Secretary could consider the financial circumstances of the individual institutions. Hearings are expected to begin June 30.



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Opinion & Dialogue

Is there a need for a drug compendium?

Government Health Official

Henry E. Simmons, M.D.
Deputy Assistant Secretary for Health
Department of Health, Education and Welfare

A drug compendium of the type I envision would fill a definite need for the practicing physician. Such a compendium would give him all the information necessary for using a drug intelligently, and it would do so in a clear, concise, convenient, objective and balanced fashion.

What a Compendium Should Contain

I believe the compendium should inform the doctor what a drug will do, when he should use it for what type of patient, for how long, in what dose, what benefits his patient is likely to obtain, the risks involved, and cross-reactions with other drugs.

The information would be based on the package insert and have the same legal status. In fact, a complete compendium with complete and current information might even eliminate the necessity

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Joseph F. Sadusk, Jr., M.D.
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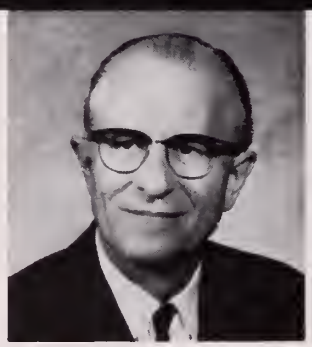

A drug compendium, or preferably compendia, should, I believe, be private, not federal, in sponsorship. They should contain comprehensive listings of drugs available for prescribing. They should be single, legibly printed volumes of reasonable size, updated quarterly or semiannually and completely revised every year.

Function of a Compendium

A compendium should furnish the following information on drugs in the following order: indications for use, side effects, adverse drug reactions, contraindications, drug interactions, drug dosage and the dosage forms marketed. Drug prices should not be included because they vary so widely and change rapidly.

No compendium should set forth drugs of choice or discuss relative efficacy. Such questions must be left for the practicing physician to decide, whether on the basis of the medical literature, his own clinical experience, advice of colleagues, information supplied by manufacturers, and so on.

Nor should a compendium undertake to educate the doctor on how to use drugs. Rather, it must be a reference source designed primarily to refresh his memory as to drugs he may not use regularly. It

for a package insert in many instances. This would constitute a substantial saving for the manufacturer.

By a complete compendium, I do not mean a volume of prohibitive size. You don't need a book describing 25,000 products with an enormous amount of repetition. Rather, drugs should be arranged by class. Mutually applicable information would be provided, along with brief discussions pinpointing differences in specific drugs of that class. Listings would be cross-indexed in a useful way.

Other Available Documents as Sources of Information

Existing references such as PDR and the AMA Drug Evaluation are obviously useful but they are incomplete. Either they are not cross-referenced by generic name and do not group drugs with similar characteristics, or they do not list all the available and legally marketed drugs. And some of those omitted may be very useful. On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

---

should in no way imply control over the practitioner's prerogatives.

Why Another Compendium?

A practicable, single-volume compendium cannot, nor is it necessary to, include all drugs on the market today. From my practice of internal medicine for some 15 years, my experience as a consultant, and as a faculty member of four or five medical schools, I would estimate that a doctor uses only 30 to 35 drugs regularly. The 1972 Physicians' Desk Reference, incidentally, contained about 2,500 entries.

As to whether there should be a federal compendium, in my opinion, as stated earlier, the answer is easy—there should *not* be one. The proposal assumes that existing compendia are inadequate. We're not sure of that at all. Whatever its imperfections, the present drug information system in the U.S. is open, multifaceted, pluralistic and extensive. Good compendia exist, as well as other ample sources on drug therapy, ranging from journal literature through AMA Drug Evaluation to company materials. Not all physicians may use such sources as often or as well as they should, but that is the fault of the man, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

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THE NEBRASKA MEDICAL JOURNAL

WHERE ARE THE GIANTS?

Dempsey, in his prime, could have beaten anybody else in *his* prime, except maybe Marciano. And Marciano was better than anybody else except Dempsey. Steinitz would have defeated Spassky, and Morphy would have checkmated Fischer any day in the week. Babe Ruth and Red Grange and Bobby Jones and Ty Cobb would do very well today, I think.

But was Withering better than Osler? Was Halsted as good as Wangensteen? Would you have wanted Hippocrates for your doctor? Would you choose Cushing, if he were alive today, or Semmelweis, or Galen? Would you ask Horace Wells to give you an anesthetic, or Trendelenburg to operate on you?

Well, Steinitz is gone, and so is Hippocrates, and Ty Cobb isn't around any more. And contests that never took place are judged only in the hot-stove league. We will never know if Will Mayo was as good as Billroth, or Charles Mayo better than Polya.

But we can think fondly of these wonderful people, while we avoid assuming that someone now alive and in his prime is the best that ever was; it is too easy to prove both ways, and the proofs will not stand up, nor are they meant to

And where are the giants today? A few are still with us, but the star system does not apply to us any more. The small handful of far-away isolated citadels is in the past, and medical centers are everywhere. Communication is instantaneous and far-reaching, and those who would be giants are dissolved in monolithic teams and immersed in mammoth centers Research is complex and computerized, and the stars are gone; the names of men have given way to names of places, and the places have become the giants, I suppose.

But there will be more, people, I mean.

—F.C.

ARE MY GERMS DIFFERENT FROM YOUR GERMS?

Germs are like electrons, they are all around us. And when I sat for examinations on so many occasions, I was disturbed to learn that there were so many of them. But while we dwell in a sea of microbial ambience, there are lakes and pools from which we are usually sheltered. And when the customary protective barriers come down, and we are exposed to tiny hostile creatures whose one desire is to do us in, it is then that we sicken and begin to die.

We cannot go about our lives wearing gloves and masks. And if people sneeze near us or cough at us or shake our hands or kiss us, why then we do not want to be exposed to whatever microorganisms they may be harboring.

But there are only so many of these disease-producing microbes, and we must assume somehow that we do not have our friend's bugs, but that we have our own, and we are used to ours. Being accustomed to our bacteria and viruses means that we live with them in a state of armed truce, what with pathogens and antibodies, and the germs may even share our feelings.

There is a countable number of microorganisms that offend us, and the billions of people in the world would need to be paired with billions of different diminutive deadly life-forms, if we do not share our parasites. It may be that I am used to my pneumococci, but not to yours, or it could be a matter of dosage, so that your viruses are present in overwhelming numbers, or are overly virulent, even though I may have met them not too long ago.

What is in your mouth and on your hands seems to be your very own, and what's mine is mine, and I am used to my little parasites but not to yours, and that is why I will not shake hands with you, and editors are almost never kissed, anyway.

—F.C.

OUR FUNNY BONES

When we ail, we are a bag of bones; and when peace-disturbers dig us up after we have slept for a century, our remains, if we have not been mummified, are our bones. I do not know why bones were made to linger for a thousand years after we have our last need of them; it seems wasteful when other parts of us sensibly refrain from outlasting their usefulness. But that is what gravediggers and archeologists find, just bones. Skin and eyes and nerves and, of course, muscles go quickly, but bones remain. Of course, everything is lifeless then, but that does not matter to bones. They go right on doing their thing, being hard and everlasting.

Skeletons may be on the outside or on the inside, and I vote for the outside, where the hard parts of us can ward off the slings and arrows that go with everyday life. But the heart and lungs are only intermittently covered by thin bony ribs, and the underbelly is entirely unprotected.

Bones moonlight, you might say, for in addition to holding us upright and to furnishing hitchingposts for muscles, they make blood in their spare time.

Bones involve the medical student too, happily or not, for, while he must painfully learn to tell the left clavicle from the right, and to distinguish one vertebra from another, a box of bones assigned to a first-year student will always get him a seat on a crowded bus or train.

—F.C.

NEW LAMPS FOR OLD

Substituting for missing or imperfect parts of the human body is old, and it may have begun with the wooden leg, and the hook-for-a-hand. The ladies beat us to it with their hair dye, nail polish, lipstick, rouge, eye shadow, and powder; to which they then added wigs, false nails, false eyelashes, and falsies.

Our dental friends were early contributors in this area with their false teeth, which Washington may have worn, made of wood or ivory, depending on the storyteller.

And now we have transplants, of the kidney, heart, lung, pancreas, and liver. To these have been added the cornea, skin, hair, blood, and marrow.

Then came the prostheses: the hip, knee, elbow, knuckle, the hand, the jaw, and the eye that does not see. And there are hearing aids and eyeglasses, with Franklin's bifocals and contact lenses and light-sensitive lenses, and bone grafts and dialysis; and the pacemaker, the cardiac balloon, and the eye that will see.

The list is long. If there is a lack of insulin, or of thyroid or parathyroid or adrenal substance, we replace them. But where does all of this take us?

In the end, our patients die, and we die along with them. Our trip is short, and our aim is to make it easier. New lamps for old has not always been a fruitful exchange, but it is all we have.

—F.C.

THE DOCTOR'S BILL

I called some furniture movers once, and this is what I was told. We charge from the time the truck leaves the office till it arrives back at the office. We don't work nights. We can move you on Saturday, but we charge time and a half for that. We don't work Sundays.

Well, I've worked many nights, and Saturdays, too. And I didn't charge time and a half, and I didn't charge from the time I left my home until I was back there. And I did work on Sundays, lots of them.

A record player that had been working before moving never worked again afterward, and my new carved-wood bookends were broken, but they said they were not responsible and not insured for things like that.

And I didn't hold my hand out for the money before I left; but they did.

If you think staying well is expensive, try moving, or eating, or driving, or clothing, or anything.

—F.C.

Interrelations Between 17 Ketosteroids, 17 Ketogenic Steroids, Body Weight, and Height in Normal and Obese Women

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and
ROBERT P. HEANEY, M.D.‡

Abstract

URINARY excretion of 17 ketosteroids (17KS), 17 ketogenic steroids (17KGS), and creatinine were measured in a cohort of 162 females between the ages of 35 and 45. This group represented 81 percent of the entire population of nuns of this age range from religious orders with headquarters in Omaha, Nebraska. Height and weight were also measured. A second group of women consisting of all those over 20 years of age, over 165 pounds (75 kg) in weight, and who had measurements of urinary 17KS excretion were selected from the laboratory records of Creighton Memorial St. Joseph's Hospital, Omaha, Nebraska from the years 1967-1971. A third group of women who met all the criteria for the obese group, except that they weighed less than 165 pounds, were selected from the same hospital records. In the nun group none of the parameters of body mass correlated with 17KS or 17KGS excretion either alone or combined in multiple or partial correlations. Likewise, none of the parameters of body mass in the obese group were correlated with 17KS or 17KGS excretion. Age was negatively correlated with 17KS excretion in this group and mean 17KGS excretion was significantly greater. Mean 17KS and 17KGS excretions in the third group of nonobese hospitalized women were not significantly different from the means in the nun group. We conclude that body mass has no influence on 17KS excretion in normal women and that a variable associated with increased body weight, but not weight itself, is responsible for increased urinary excretion of 17KGS in obese women.

Introduction

The clinical findings of obesity, hirsutism, and menstrual irregularities occurring in a female are usually considered indications for measuring urinary excretion of 17 ketosteroids (17KS) and 17 ketogenic steroids (17 KGS) in order to rule out Cushing's disease, adrenogenital syndromes, or androgen secreting tumors of various types. It has been said (1) that the normal upper limit for urine 17KGS or 17KS excretion obtained in any individual female patient must be corrected upward for increasing height and weight. While this relationship seems to be well established in males according to Tanner[2] and others,[3] the situation in females seems much less clear.[3-7]

In this study we are reporting the results of urinary 17KGS and 17KS excretion in a well defined population of free living women (Group I), in a group of hospitalized obese women (Group II), and a group of hospitalized nonobese women (Group III).

Methods

Group I. Subjects in Group I were 162 nuns between the ages of 35 and 45, a cohort comprising 81 percent of the entire population of nuns of this age range from the religious orders with headquarters (motherhouses) in the area of Omaha, Nebraska. They were professional workers, such as teachers, nurses, and administrators who were employed at the time of the study. None of the members of this population of nuns was excluded by the investigators. The 19 percent who were not studied did

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not volunteer when the study was instituted, though the opportunity was offered to them.* Of those who were included, 22 had undergone surgical or spontaneous menopause at the time of the study, and 6 (including two premenopausal women) were being treated with various estrogen preparations.

Each subject was admitted to the Creighton University Metabolic Research Unit for an 8 day study period. Protein, carbohydrate, and fat intakes were held constant for each subject at a level estimated to equal the usual dietary intake as determined by interview by a trained dietitian. The menus were consumed in the Metabolic Research Unit under the supervision of a specially trained metabolic nurse.

Urine 17KS excretion was determined by the method of Drekter[8], urine 17KGS by the method of Rutherford and Nelson[9] and urine creatinine by the alkaline picrate method.

Group II: The records of the clinical laboratory, Creighton Memorial St. Joseph's Hospital were examined for the years 1969 through 1971. All patients who were female, over 20 years of age, over 75 kg (165 lb) in weight, and had measurements of urinary 17KS excretion were selected for analysis. Patients with a documented diagnosis of Cushing's disease, Addison's disease or hypopituitarism were excluded, as were all patients who were members of Group I, or whose 24 hour urine volume was less than 1 liter. Forty-one patients met the above criteria and were included in Group II.

Group III. A third group was analyzed for 17KS excretion. The inpatient records for all women who met the criteria for Group II, but whose weight was less than 165 pounds were included. Of this group of 24 women, 13 had measurements of 24 hour urine 17KGS excretion.

*These women were volunteers for a 20 year prospective survey of women at risk for osteoporosis. The results reported here were part of a total of 69 different variables measured or calculated on each volunteer at five year intervals.

Results

The findings are summarized in Tables I, II and III. The mean age was not significantly different in the groups but the age range in Group I was, by definition, between 35 and 45, in Group II between 21 and 80 in Group III between 21 and 73. The mean height was similar in all three groups, 1.632 m, 1.618 m and 1.616 m, while the mean weight was significantly greater in

Table 2
CORRELATION COEFFICIENTS, GROUP I

	17 Keto-Steroids	17 Ketogenic Steroids
Height	.1220	.1449
Weight	.0664	.1191
Creatinine	.0778	—.0058
Age	—.0454	—.0406
Height-Weight*	.1260	.1634
Ht-Wt-Cr*	.1337	.1839
17 Ketogenic Steroids	.6113+	

* Multiple correlations
\+ $P < .01$

Table 3
CORRELATION COEFFICIENTS, GROUP II

	17 Keto-Steroids	17 Ketogenic Steroids
Height	—.0877	—.1616
Weight	.2360	.2009
Age	—.3333+	.0581
Height-Weight*	.2623	.2463
Ht-Wt-Age*	.4269	.2789
Weight-Age*	.3417	.1700
17 Ketogenic Steroids	.4626†	
Age (Wt Constant)**	—.3500+	.1996

* Multiple correlations
** Partial correlations
\+ $P < .05$
† $P < .01$

Table 1

	GROUP I			GROUP II			GROUP III		
	X	SD	N	X	SD	N	X	SD	N
Age	41.3	3.5	162	38.2	15.9	41	45.2	15.6	23
Height(M)	1.632	.067	162	1.618	.068	36	1.616	.148	21
Weight (kg)	61.66	10.38	162	94.0*	20.8	41	58.98	9.08	24
Cr (g/d)	1.159	.207	162	---	---	--	---	---	--
17KS mg/24 hr	11.8	4.9	162	11.5	4.5	41	10.8	5.1	23
17KGS	10.6	3.7	162	13.3*	7.3	31	9.8	5.1	13

* $P < .01$

Group II ($P < .01$). In Group I, daily caloric intake averaged 1779 ± 385, and mean protein intake was 70.5 ± 16.7 gm per day. Mean 17KS excretion in Group I (11.8 ± 4.9 mg) was nonsignificantly different from the mean in Group II (11.5 ± 4.5 mg) or Group III (10.8 ± 5.1 mg). Mean 17KGS excretion in the obese group, 13.3 ± 7.3 mg, was significantly greater than the mean in the nun group, 10.6 ± 3.7 mg per 24 hours ($P < .01$). In order to determine whether this finding was due to systematic laboratory variation or was in some way peculiar to inpatients regardless of body weight, the inpatient records for Group III were reviewed. In this group, the mean 17KGS excretion was 9.8 ± 5.1 mg, a value nonsignificantly different from the mean in the nun group, but significantly less than the obese group.

Three variables, height, weight, and 24 hour creatinine excretion, were used as indicators of body mass in the nun group. The regressions of urinary excretion of 17KS and 17KGS on each of these three variables were calculated by the method of least squares. The correlation coefficients are listed in Table II. None of these was significant, nor were the multiple correlations using these same three variables in any combination with the steroid excretion data.

The regression of each category of steroid excretion on age was calculated for the nun group and nonsignificant correlations were found, though the age range of 35 to 45 may have been too small to allow a significant correlation to emerge.

Height and weight were the variables used as indicators of body mass in the obese group. 17KS excretion was not significantly correlated with height or weight, nor with these two variables combined in a multiple correlation. However, there was a significant negative correlation with age ($r = -.333$, $P < .05$, Figure 1). The partial correlation with age remained significant with weight held constant.

None of the correlations calculated for the regressions of 17KGS excretion in the obese group on the variables of height, weight or age emerged significant, either singly or in any combination of multiple or partial correlations.

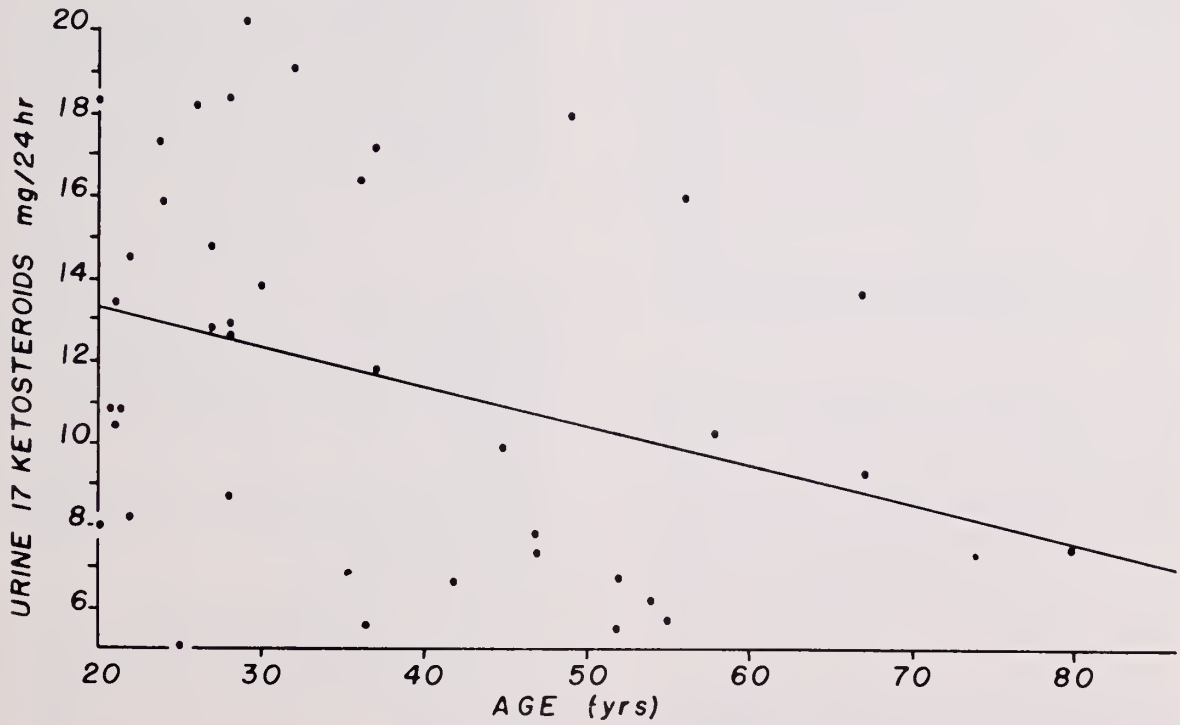

Figure 1. 17 Ketosteroid excretion as a function of age in 41 women over twenty years of age and over 165 pounds in weight ($r = .333$, $p < .05$).

Discussion

There was no correlation in this study between 17KS excretion and body weight in Group I. This was a very homogeneous group and represents nearly all members of the entire population as defined. Factors that may tend to obscure the relationship between body mass and 17KS excretion such as age, occupation, history of child bearing, are absent or remain constant. Furthermore, there was no significant multiple correlation between 17KS excretion and any of the measures of body mass (height, weight, and creatinine excretion) in any combination. We conclude that 17KS excretion is not influenced by body mass in normal women aged 35 to 45.

Group II was a more heterogeneous group, more heavily weighted with younger members, having had urinary ketosteroid measurements performed for a variety of reasons, mostly because of hirsutism and menstrual irregularities and selected for inclusion because of a body weight in excess of 75kg. Again, no significant correlation between 17KS excretion and body weight emerged, nor was the multiple correlation of 17KS excretion with weight and height significant. Only age correlated with 17KS excretion (negatively) and even this was weak ($r = -.333$, $P < .05$, Figure 1). The multiple correlations with height, weight and age yielded slightly higher r values but did not reach significance. We conclude that body mass has no influence on 17KS excretion even in obese women, and that only a small correction for age need be made in the clinical interpretation of this laboratory value for any individual adult female patient.

This conclusion is not incompatible with Tanner's findings[2] of positive correlations between 17KS or 17KGS excretion and body weight in young males. If lean body mass influences 17KS excretion but fat mass does not, a link between body weight and 17KS found in his lean young English males might easily be obscured in older fatter United States females.

Although there was no relationship between body weight (or any parameter of body mass) and urinary 17KGS excretion in the nuns *or* the obese women, the latter did have higher excretion as a group. Previous authors[11, 12] have also noted increased 17KGS but not 17KS in obese women. This would suggest that some variable associated with increased weight, but not weight itself, is responsible for the increased urinary excretion of 17KGS.

High protein intake may affect steroid excretion. Schteingart and Conn[10] demonstrated that cortisol secretory rate, urinary 17KGS, urinary 17KS and glomerular filtration rate all increased during high protein intake and decreased during isocaloric low protein intake while plasma cortisol remained unchanged.

Protein and caloric intakes in these obese women are likely to be considerably above (perhaps 50-100% greater) the 70 gram and 1700 calories respectively found in the nun group. Increased protein intake is an attractive explanation for the observed increase in 17KGS in the obese group. However, increased excretion of 17KS also should have been found if this mechanism is responsible.

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Emergency Transportation of the Neonate*

PART III

Problems of Financing Transportation of the Neonate

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A precise estimate of cost involved in transporting high risk infants is not readily available. The cost of equipment necessary for adequate transport of a high risk infant in an ambulance or mobile hospital van would include approximately $1,500 for a transport incubator; $400 for infusion pump to maintain I.V. infusion during transport; the cost of equipment to administer positive-pressure ventilation varying anywhere from $60 for a HOPE resuscitator to $7,000 for a Bourne Respirator; and cardiac monitoring equipment would cost approximately $1,000. The cost of disposable equipment, of cleaning and maintaining the unit, and for medication vary significantly. The approximate cost of a mobile hospital van such that currently utilized by the University of Nebraska Medical Center ranges from $25,000 to $30,000.

The operating cost for ground transportation is currently 35c per mile. This would be approximately $70 for a round trip to a point 100 miles from Omaha. This figure is exclusive of physician and assistants fee. The estimated charge cost for physician to accompany the infant during transportation would be from $50 to $100 per trip. In contrast, the cost of air transportation of infants turns out essentially to be the same. The current charges for chartering an airplane is approximately 50c per mile. The differential in cost for air transport versus ground transport is off-set in the difference in cost of physician manpower because of the time saved in utilizing air transport systems. In addition to the cost of flying time for the plane, the air transport of infants must include the cost of ground transportation from the hospital to airport at each end of the trip. In terms of actual charges to the patient, the estimated cost of transporting a high risk infant for 100 miles would be approximately $250, whether by ground or by air. This figure is inclusive of ground and air transport, physician time, and equipment, but exclusive of charges for the physician's assistant, the medical student in most instances. This figure also does not include cost depreciation figures for the mobile hospital van when it is utilized.

The Experiences of the University of Mississippi Medical Center

Dr. Alfred W. Brann, Jr., director of the newborn intensive care center at the University of Mississippi, Jackson, Mississippi, spoke to the workshop participants on the problems in the state of Mississippi and some of the solutions that they had used in transporting newborns. Like Nebraska, Mississippi is a predominately rural state, with the Medical Center located at Jackson, in the south central portion of the state. While patients residing in the northern por-

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tion of the state normally go to Memphis, Tennessee for intensive care, and some of the patients residing in southwestern portions of the state might normally go to New Orleans, the majority of the state would utilize the University of Mississippi Center at Jackson as its high risk infant care center. Unlike Nebraska, Mississippi had one of the highest perinatal mortality rates in the country, with 23.4 neonatal deaths per 1,000 live births and an infant mortality rate of 39 per 1,000 live births.

Dr. Brann used the example of Holmes county, located approximately 60 miles away from the University Medical Center. The county population was approximately 23,000, with 75% of the population being rural and a median income of $3,000 per year per family. The population of the Holmes county area was 68% black, with 34% of the black infants being delivered in the hospital and 100% of the white deliveries taking place in the hospital.

To provide prenatal medical care for the area, the Departments of Obstetrics and Pediatrics at the University of Mississippi Medical School established a pilot program utilizing certified nurse midwives who had extensive training in not only prenatal care but also in care of the infants for the first year of life. Nurse midwives work in close cooperation with the private physicians in the county. They have very rigid guidelines for mandatory referral of mother or infant to the University of Mississippi Medical Center. They provide both prenatal and postnatal health care for mother and infant, with delivery being carried out at the local hospital if no complications are noted. If abnormal conditions are noted that would suggest that mother or infant is at risk, the nurse midwife calls either the obstetrician or pediatrician on call for the University of Mississippi Medical Center, setting in motion a referral system of transportation of patient from local hospital to the University Medical Center. The transportation system originates locally, with ground transportation by ambulance being utilized primarily. The result of such a system in terms of marked improvement in perinatal mortality and morbidity were presented by Dr. Brann, showing very striking impact on the utilization of the nurse midwife and the referral system. Dr. Brann hastened to point out that the most significant part of the transportation system was not the vehicle used but rather the establishment of a recognized system which could be set in motion by a single phone call from the local physician or nurse midwife to one of two phone numbers at the University Medical Center. The time lag of instituting the transport system was minimal, and the results favorable. He went on to point out that the system frequently involves the return of the neonate for continued hospitalization at the local hospital whenever the facilities of the newborn intensive care unit are no longer needed, for example, for the premature infant who is gaining weight satisfactorily and no longer requires intensive nursing skills. The program was developed under multiple sources of funding, from the Children's Bureau, the Department of Health, Education and Welfare, and from grants from the National Foundation — March of Dimes.

Dr. Brann also described another transport system that is operational in Mississippi. In a more remote section of the state, a three-county area established their own regional transport system, including the purchase of helicopters for emergency transportation. The local three county area residents felt that emergency transport both infant and adult to regional medical centers fell into the category of a civil responsibility, and have established a very effective air and ground transport system.

Resources or Potential Resources Available in Nebraska for Emergency Transportation of High Risk Infants

The most important resources for provision of emergency transportation for the high risk infant in the state of Nebraska is clearly identified as the mobile hospital van and transport services currently operated by Dr. Van Leeuwen and the staff of the Pediatrics Department at the University of Nebraska Medical Center. The availability of the mobile hospital van or the utilization of equipment in private air ambulance transportation of the infant is a significant service which will serve as the

focal point for expanded system for care. The experience of Dr. Van Leeuwen and his associates in providing transportation for approximately 400 infants, both locally and within the state and surrounding areas, provides much needed base line information about problems encountered in this area and potential solutions to these problems.

Another major resource in transporting infants was the utilization of private ambulance service for ground transport of high risk infants. This has been utilized primarily for transportation of infants outside of the metropolitan Omaha area. The major advantages in utilization of local ambulances include the elimination of long time lag for travel of the vehicle to the referring hospital to pick up the infant and the ready availability of such services within each community in the state. The disadvantages include the inaccessibility of trained personnel to accompany the infant in many instances, and the lack of sophisticated equipment needed for transport of infants. The latter problem can be partially solved by the strategic location of transport incubators at local and regional hospital centers around the state. Mr. Marty Miller, of Eastern Ambulance Company, Lincoln, spoke about the problem of financing transportation of infants by private ambulance, noting that the financial burden encountered was a significant one and that private enterprise companies cannot maintain a large burden of write-off costs in transporting infants.

The third major resource identified was the availability of private charter aircraft for air ambulance service. Dr. William Orr, Associate Professor of Obstetrics at the University of Nebraska Medical Center, spoke of the technical requirements and their sources available through private air charter systems. Dr. Orr is a pilot and part owner of an air charter service located in Omaha. The ready availability of private air transportation of a charter basis, particularly when a team provides the equipment and skilled medical personnel for transporting high risk infant is a major resource to the state. Dr. Orr again commented on the financial impact on the utilization of such a system noting that total cost for transporting infant by air for a distance of greater than 100 miles is no more expensive than utilizing ground transportation for such a distance because of the saving in professional time.

Another major resource are facilities available through Air National Guard, the Twenty-Fourth Medical Company Air Ambulance Unit. While the National Guard has available large numbers of helicopters stationed in Lincoln, the Air National Guardsmen, must be mobilized, and are not skilled at providing medical assistance during transportation of patient. The limitation on availability of Air National Guard currently involves the need to limit their use for "last resort" situations and the time lag of mobilizing crew and servicing the helicopter, except during weekend times or when crews are operational for training purposes. Mr. Miller stated that the access to the Air National Guard must come by the way of notification of a local law enforcement agency, usually the sheriff's office or state highway patrolman who would contact the state Civil Defense duty officer to process the request for mobilization of Air National Guard services.

Another major resource that has been used on several occasions is the Nebraska Highway Patrol. Colonel James Kruger spoke of the limitations of services through the highway patrol, pointing out that they are primarily a law enforcement agency and lack equipment for providing emergency transport of infants. However, their utilization on occasions has been extremely important in assisting other systems of transportation. He also pointed out that they should not primarily be utilized as an escort service, for such a function is not only time consuming but frequently carries with it significant risks for accidents involving the vehicle being escorted, particularly when it is not driven by a professionally trained driver.

Primary Hepatoma and Invasive Lobular Carcinoma of Breast Without Cirrhosis

CHARLES SWEET, M.D.
and
JOSEPH A. SISSON, M.D.*

HEPATOMA or hepatocellular carcinoma of the liver is a relatively rare tumor in this country, occurring in .02 to 0.69% of patients autopsied.[1,2] Approximately 79% of hepatomas arise in preexisting cirrhosis,[2] predominantly in cirrhosis of the post-necrotic variety.[1,2,3] Hepatoma occurs more frequently in males in a ratio said to be approximately 4:1[2] to 6:1.[1] Except for childhood hepatomas, the predominant or peak age of occurrence of hepatomas is in the late 6th and early 7th decade.[1,2] In a recent study of cirrhosis and hepatoma, only 29% of hepatomas were diagnosed antemortem. In the same study of cirrhosis and hepatomas, 7% of the patients had other primary malignancies, and 2% of the hepatoma patients had primary breast carcinoma although the microscopic type of breast carcinoma was not specified.[2]

Case Report

Clinical History:

This 77 year old lady first presented with a history of increasing abdominal bloating and GI distress in August, 1971. It was noted that she had a large liver, and in view of negative finds otherwise, a laparotomy was performed in November, 1971, which revealed a large tumor of the liver. Liver biopsy revealed a hepatoma. She was given a course of irradiation therapy. Then 5 fluorouracil and Oncovin were given and were tolerated well until April, 1972 when she had an episode of gastrointestinal bleeding. At this time a 6 week hospitalization was necessary with blood transfusions to correct the anemia due to GI tract blood loss and chemotherapeutic depression of the bone marrow. Again, chemotherapy was started with methotrexate 1.25 mg daily. She tolerated this quite well until September, 1972, when she again had abdominal bloating and swelling. At this time paracenteses were done approximately every 3 to 4 weeks, usually yielding 4500 to 5500 ml of exudate fluid. She tolerated these paracenteses quite well and she subsisted on a very meager diet. In January, 1973, on a routine examination, a 1 cm nodule was found in the left breast. This was subsequently biopsied and proved to be an invasive lobular carcinoma (ILC) without lobular carcinoma in situ (CIS). The microscopic pattern of this (ILC) without lobular (CIS) is seen in Figure 1. At this time she was also found to have diffuse nodules in the lung fields on x-ray examination. In March, 1973, the chemotherapy was changed to Oncovin at weekly intervals. Approximately 2 days after the third dose, she began having nausea and vomiting, and presented with a picture of ileus. As the ileus progressed, she was not able to tolerate any feedings, and her condition deteriorated, and she expired in May, 1973, 22 months after the initial onset of symptoms. There was no history of hepatitis, excessive alcohol ingestion, or exposure to any known hepatotoxic agents such as aflatoxins, cycad palms, nitrosamines, analine dyes, carbon tetrachloride, or exogenous estrogen ingestion.

Postmortem Findings:

At autopsy, the patient was markedly cachetic. The major findings otherwise were in the abdominal cavity with 4500 ml of serofibrinous ascites. The liver weighed 1200 gm. There was a

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multicentric tumor mass measuring 10 x 6 cm with a trabecular pattern and areas of necrosis and hemorrhage. The remainder of the liver was soft, and there was no evidence of cirrhosis grossly or microscopically. Figure 2 shows the gross appearance of the cut surface of liver with the trabecular, multicentric, hemorrhagic tumor on the left and the smooth, noncirrhotic liver on the right. The only other place where tumor was found at autopsy was two nodules of metastatic hepatoma in the lungs. Otherwise the abdominal cavity showed only fibrous and fibrinous adhesion. At autopsy no residual breast tumor was present; some ductal hyperplasia of the breast was seen. The microscopic pattern of the hepatoma is shown in Figure 3 with the typical pattern of primary liver cell hepatoma with plates and cords of somewhat hyperplastic liver cells.

Discussion

We have reported a case of hepatoma and invasive lobular carcinoma of the breast (ILC) occurring in a 77 year old white female without cirrhosis or history of previous exposure to known hepatotoxins. The usual preexisting or etiologic factor in 79% of hepatomas is cirrhosis of the liver. Other etiologic agents for hepatoma include aflatoxin from mouldy ground nuts,[3] azo-glucosides from cycad ingestion.[3] Other toxic agents used to produce hepatomas in experimental animals are butter yellow, nitrosamines, some analine dyes, and carbon tetrachloride.[1] Alcohol ingestion in association with preexisting cirrhosis of the liver is the most common known agent to be associated etiologically with hepatomas in this country. The difference between low incidence of primary hepatoma in this country and the high incidence in Africa probably represents the tumorogenic effect of such environmental factors as those outlined above which are

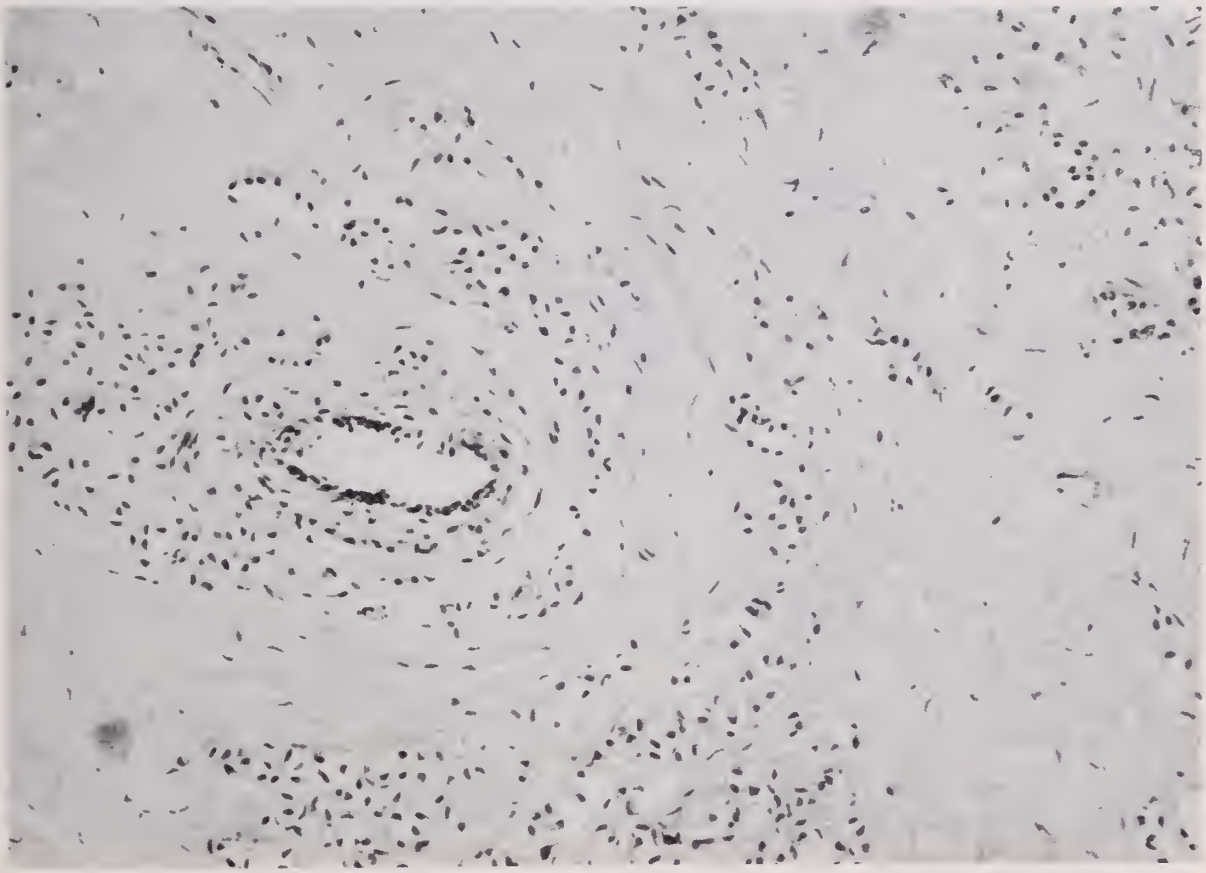

Figure 1. Invasive lobular carcinoma of the breast without lobular carcinoma in situ showing typical haphazard arrangement of cells and some ("Indian file" en filade) single file arrangement. 160X

more prevalent in areas with a high incidence of hepatomas.

Alpha-fetoprotein (AFP) is present in the serum of at least 66% of patients with hepatomas, and an (AFP) analysis should always be performed on patients with a rapidly enlarging liver suspected of having a hepatoma. Where the AFP is positive, a liver biopsy should be performed to confirm the diagnosis.

The coexistence of an ILC of the breast and hepatoma in this case is not easy to explain. There are three possible mechanisms for this coexistence: first, that the same tumorogenic factors that induced the hepatoma were operative in producing the lobular carcinoma of the breast; second, that the decreased ability of hepatoma involved the liver to detoxify estrogen or progesterone or other carcinogenic compounds lead to their accumulation and the production of the lobular breast carcinoma. The third possibility is that the lobular breast carcinoma arose *de-novo* independent of the hepatoma. Because of the lack of history of exposure to known carcinogens, we can tentatively rule out mechanism number one and can only speculate between the second and third mechanisms mentioned above.

The lobular carcinoma in this case was of the more unusual invasive lobular carcinoma (ILC) variety without the more common lobular carcinoma in situ (CIS) as described recently by Fechner[4] (Figure 1). In cases of lobular carcinoma of the breast when ILC is found without lobular CIS, the risk of carcinoma in the contralateral breast is increased even more than the approximately 25% bilateral incidence of tumore when lobular CIS is found in one breast. In seven of eight contralateral breasts studied, either invasive or noninvasive cancer was found when ILC was found in the first breast removed. When either lobular CIS or ILC is found in one breast, many investigators now agree that a contra-

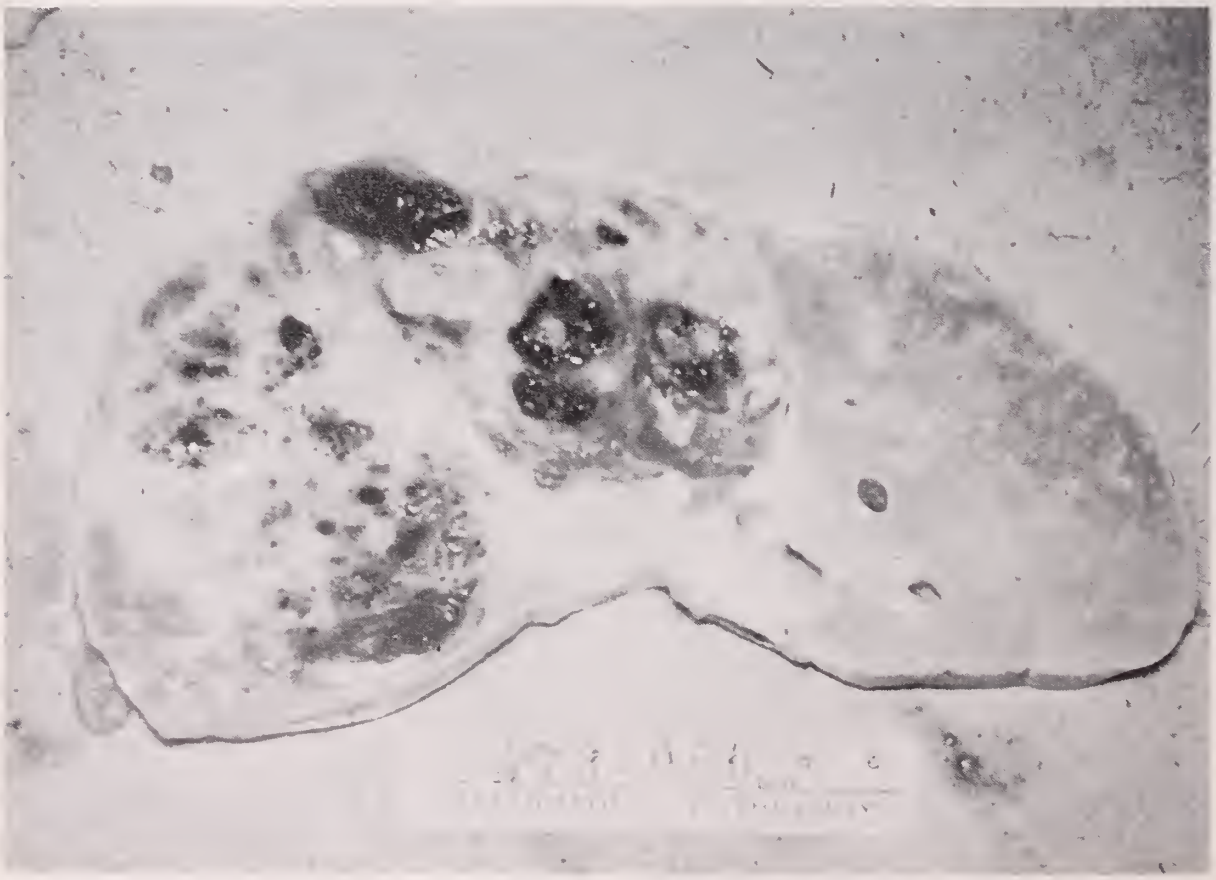

Figure 2. Gross photograph cut section of liver showing multicentric hepatoma on the left with noncirrhotic smooth cut surface on the right.

lateral simple mastectomy is justified at the same time that the primary tumor bearing breast is removed.[4]

Summary

1. A case of a simultaneous primary hepatoma without cirrhosis and invasive lobular carcinoma of the breast in a single patient is reported.

2. The possible etiologic mechanisms for the development of the hepatoma and the invasive lobular breast cancer are reviewed.

3. Several important diagnostic and therapeutic considerations in these diseases are reviewed.

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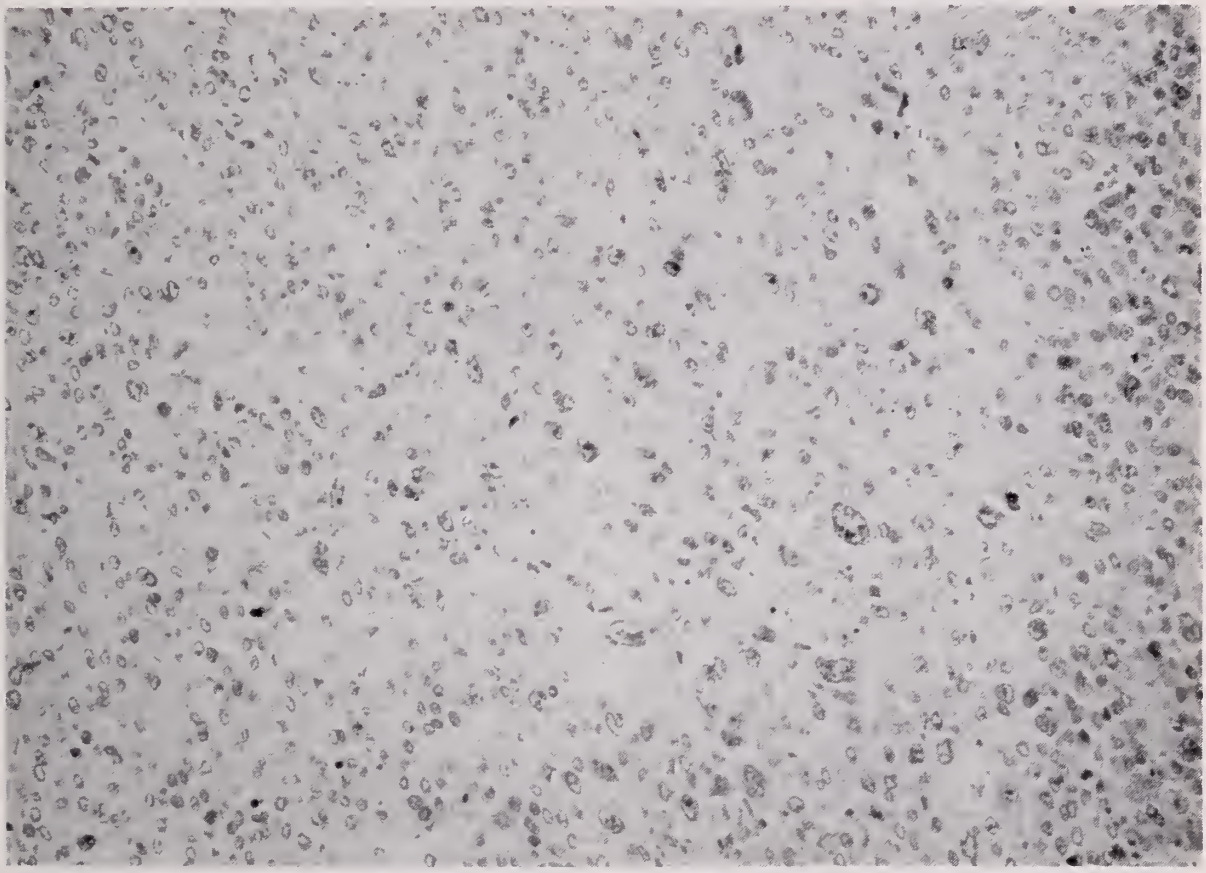

Figure 3. Primary hepatocellular hepatoma of liver with uniform nests and cords of moderately pleomorphic, hyperchromic hepatocytes. 250X

Management of a Single Seizure In Adolescents and Adults

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A single seizure in an adolescent or adult is a difficult clinical problem. Many questions are raised regarding the extent of diagnostic studies and treatment. We will consider factors in making these decisions.

Various definitions for a seizure exist. A useful one is that a seizure is a brief, stereotyped cerebral attack, inappropriate to the immediate situation, and associated with transient impairment of consciousness and amnesia.[1]

A seizure is a symptom. The diagnostic evaluation searches for the specific cause of the seizure, since only with this information can the most specific treatment and most reliable prognosis be obtained. Though anticonvulsants may well control a seizure due to a meningioma, the use of this symptom leading to the correct diagnosis with subsequent surgery and prevention of further seizures or neurologic deficit is to the advantage of the patient. Conversely, complete evaluations in patients with definite idiopathic type seizure disorders place the patient at the low, but perceptible, risk of contrast studies such as angiography without likelihood of demonstrating a more specific etiology based on our present knowledge. Consequently, the search for the cause of a person's seizure may be simple, or it may be quite difficult.

Presumptive causes of seizures vary according to several factors. Most important is the age of onset at the time of the first seizure. In adolescents (age 10-20), the most frequent etiologies are (1) idiopathic or cryptogenic, (2) post-traumatic, or (3) due to birth injury. Young adult's (age 20-35) seizures are most likely due to (1) trauma, (2) neoplasm, or (3) birth injury.

Common causes of seizures in middle age (35-55) are (1) neoplasm, (2) trauma, and (3) cerebrovascular disease. Cerebrovascular disease and neoplasia are the main reasons for seizures occurring initially in patients over 55.[2] It is noteworthy that birth injury remains a common cause for the initial seizure in persons up to 35. In spite of these probabilities, one must always consider the possibility of a focal lesion requiring surgical treatment, such as a tumor, vascular malformation, or abscess, in a person of any age. Also, drug or alcohol withdrawal and metabolic causes such as hypoglycemia and hypocalcemia must be included in differential diagnosis.

Seizures are now divided into two main types, (1) idiopathic, and (2) partial, or focal. Idiopathic seizures are associated with various interictal EEG abnormalities such as diffuse spike and wave or polyspike and wave activity. The neurological examination is normal. These seizures begin without aura. Some are not associated with convulsive movements, the so-called petit mal or lapse type. The grand mal seizure consists of generalized convulsive movements of the tonic, clonic, myoclonic, or mixed types.

Focal seizures are associated with focal EEG abnormalities such as spike discharges or slow wave focus. The neurological examination may show abnormalities or may be normal. These seizures may be simple, affecting motor or sensory function; or complex, in which psychic, intellectual, or emotional dysfunction may be associated with sensory or motor activities (such as automatisms). Focal abnormalities often become diffuse and produce generalized convulsive activity indistinguishable from primary generalized seizures unless premonitory signs are observed, or EEG or other evidence of a

focal abnormality is demonstrated. Partial, or focal seizures in adolescents or adults are caused by a localized epileptogenic lesion such as tumor, vascular malformation, abscess, or scar. Seizures also occur in association with an encephalopathy of central (encephalitis, meningitis) or systemic (hypoglycemia, hypertensive encephalopathy, hypocalcemia, sodium imbalance) origin.

The diagnostic evaluation begins with a thorough history. Though some patients may describe the aura of the seizures, most can give no information about their episode. This makes it imperative to interview an observer of all or part of the seizure. The observer is questioned regarding any premonitory signs. The onset of the attack is recorded, with the observer specifically asked about initial movements of eyes, head, or extremities. This information is helpful in differentiating focal from generalized seizures. The main portion of the seizure is then determined with observations on type of movements if present, behavioral manifestations, and level of responsiveness. The termination of the seizure is recorded including postictal state and behavior, such as any weakness or speech disturbance. Specific questioning is necessary regarding drug or alcohol abuse and withdrawal, and the use of insulin for diabetes mellitus.

Neurological examination is rarely possible in the immediate postictal period. The patient is usually seen after he has recovered from the effects of the episode. The neurologic examination is often normal. If abnormalities such as hemiparesis, asymmetric muscle stretch reflexes, pathologic reflexes, or sensory loss are demonstrated, a focal cause of the seizure is presumed. However, the presence of a normal neurologic examination in no way excludes the possibility of a focal seizure disorder.

Differentiation of seizures from other paroxysmal phenomenon is based primarily on analysis of the reported observations and on results of studies discussed later. The major conditions which are differentiated from seizures are syncopal attacks, hyperventilation, hysterical episodes, and transient ischemic attacks.

Syncope is characterized by variability in intensity, duration, and character of warning symptoms from one attack to the next. These warning symptoms consist of weakness, lightheadedness, nausea, perspiration, pallor, and blurred vision. In syncope, consciousness is probably never lost as suddenly as in seizures. Though patients who have fainted are often flaccid, stiffening of the body and brief twitching of the arms or face are not unusual. Contrary to seizures, after a faint the patient is rarely confused and usually is aware he has had a spell.[1]

Hyperventilation attacks are usually not associated with loss of consciousness, and when this occurs, it is preceded by anxiety, palpitation, breathlessness, paresthesias, and occasional carpopedal spasm.

No absolute criteria exist to differentiate seizures from "hysterical" seizures. The level of consciousness during an attack is the best guide. If a patient can be aroused during an attack, it is unlikely that a true seizure has occurred.[3] The coexistence of true seizures and hysterical seizures in a patient must be considered, and is a difficult diagnostic and therapeutic problem.

Transient ischemic attacks are differentiated by the absence of loss of consciousness and the presence of paresis rather than convulsive movements when motor phenomena are noted.

Diagnostic studies in a patient with a seizure vary from case to case. At times an electroencephalogram may be the only test needed beyond the history and neurological examination. A more complete evaluation would include EEG, skull x-ray, echoencephalogram, serum calcium, tests of glucose metabolism, and brain scan. In occasional cases, contrast studies such as pneumoencephalography or arteriography are indicated.

The EEG is the single most valuable test in the evaluation of seizures. As mentioned, the EEG often gives information indicating the type of seizure disorder present. This helps direct the course of further studies. However, the EEG is not generally useful in determining the nature of a focal lesion when

it exists. Several technical points concerning the EEG are of importance. First, when a seizure is suspected, the EEG should include recording with the patient awake and sleep. This usually requires presedation. Many interictal abnormalities are noted most frequently in the stage of light sleep and are not apparent with the patient awake. Secondly, if the patient is receiving anticonvulsant medication, this need not be discontinued for the performance of the EEG. Thirdly, an EEG is often helpful even when performed within 24 hours following a seizure. The presence of focal type EEG abnormalities generally establishes the need for further studies as noted above.

No matter how many studies are done, the cause of a single seizure is often not determined. Though the absence of positive findings is reassuring, careful follow-up with repeat neurological examinations and EEGs as clinically indicated are recommended.

The use of anticonvulsants in a patient with a single seizure is a controversial topic. In a study of 48 patients with a single seizure, 27% had subsequent seizures.[4] With a recurrence rate of this magnitude, it is our general policy to treat adults and adolescents who have had a single seizure with anticonvulsants. Initial drugs of choice for generalized seizures include phenobarbital or diphenylhydantoin. A single drug initially is preferred so that side effects and toxic reactions may be accurately assessed. If a patient has no further seizures, and if the follow-up EEG is normal, consideration is given to gradually discontinuing anticonvulsants after one to two years. However, as in all general rules, we make frequent exceptions to the above.

Certain seizures have a particularly low incidence of recurrence. These include seizures which occur at the time of a cerebral infarct or cerebral injury. Seizures occurring two weeks or more after a cerebral infarct are much more likely to recur than those occurring at the time of the infarct.[5]

Finally, several factors exist which are within the patient's control relative to seizure occurrence and frequency. Of these, the most significant triggering factors are irregular and inadequate sleep, alcohol consumption, long periods without eating, and sudden medication withdrawal. Consideration of these factors is important in assessing recurrence of a seizure and the need for medication adjustment.

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Prediction of Serum Cholesterol

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ALTHOUGH some uncertainty exists regarding the use of serum cholesterol as an indicator of coronary heart disease (CHD) candidacy, the epidemiological studies by Dawber, Moore, and Mann,[8] Doyle,[9] Chapman and Massey[6], and Ostfeld, Paul, and Lepper[16] show the relatively high association of serum cholsterol with CHD incidence. Moreover, serum cholesterol apparently reflects the concentration of Gofman S^r, 12-20 lipoprotein, which in turn is commonly elevated in atherosclerotic subjects.[2] Thus, in view of the apparent clinical importance of serum cholesterol, an efficient prediction thereof might be of some practical value.

Purposes

The main purpose of the study was to predict serum cholesterol via multiple regression techniques. Other purposes were:

—to interrelate serum cholesterol with selected anthropometric, cardiovascular, nutritional, and physical fitness variables; and

—to determine the mean, standard deviation, reliability, and reproducibility for two independent methods of analyzing for serum cholesterol — the Hycel* method and the Unitest† method.

Methods

Subjects. 51 subjects, ranging in age from 19 to 63 years (mean = 38.7 years), volunteered their cooperation. Only 6 subjects led what might be considered sedentary lives; the rest were engaged in supervised physical training programs (rhythmic endurance type) or took voluntary habitual exercise.

Testing Procedures. The blood samples were drawn between 11:00 a.m. and 1:00 p.m. Owing to the effect of posture on serum cholesterol,[7] the postural condition was standardized to the extent that the subjects stood or walked for 10-15 minutes, then sat down for the sampling of blood. The subjects were instructed not to take any food, beverage (except water), drugs, tobacco, etc., in the time interval between breakfast and their scheduled appointment; breakfast *ad lib* was permitted, since Calories, grams saturated fat, and % saturated fat in breakfast were to be used as independent variables. The subjects were also instructed to avoid deliberate exercise on the morning of their appointment. Subjects were asked to report incidences of extreme psychic stress that may have occurred on the morning of their appointment; in such cases, the cholesterol test was postponed. Split samples of blood were analyzed at the Physical Fitness Research Laboratory of the University of Illinois (Unitest method) and at the Mercy Hospital Clinical Laboratory in Urbana, Illinois (Hycel method). Neither laboratory was conscious of the results of the other laboratory. At each laboratory a repeat determination was made on 12 samples to assess the reproducibility of the method. The outside temperature on days blood was sampled ranged from 13 to 70° F.

The testing of the independent variables was conducted at the Physical Environment Laboratory of the University of Illinois between 7:00 p.m. and 11:00 p.m. Temperature ranged from 75 to 82° F, while relative humidity ranged from 22 to 46%. Subjects were asked to follow written instructions regarding their preparation for the tests. These instructions specified a relatively light supper, no deliberate exercise on the day of the test, and abstinence from stimulant or depressant drugs during and after supper. Table 1 lists the independent variables. Heart rates in the PWC_{170} test

*Hycel, Inc., P. O. Box 36329, Houston, Texas 77036.

†Bio-dynamics, Inc., Indianapolis, Indiana.

and Astrand-Rhyming test were corrected for age via the correction factors given by Irma Astrand.[1] The cardiac time intervals were measured from simultaneous tracings of the phonocardiogram, carotid pulse wave, and ECG (lead II), according to the methods of Blumberger and Meiners.[3] A factor analysis of the cardiac time intervals was published by Franks and Cureton.[10] Figure 1 depicts a typical recording. Pulse transmission velocity was determined by dividing the aortic-valve-to-finger arterial distance (measured from third interspace at sternum to medial end of left clavicle to lateral end of clavicle to tip of left index finger) by the pulse transmission time from aortic valve to finger (measured from the second heart sound to the incisural notch of finger pulse wave). The skinfolds comprising variable 17, sum of 6 skinfolds, were: cheek, abdominal, hip, gluteal, front thigh, and rear thigh. These same 6, plus the remaining 4 from Table 1, comprised variable 18 — sum of 10 skinfolds. Specific gravity was predicted via the Brozek and Keys formula.[5] The 4 muscle girths involved in variable 24 were: biceps, calf, thigh, and gluteal. The breakfast variables were obtained

Table 1

INDEPENDENT VARIABLES

VARIABLE	UNIT OF MEASUREMENT
1. Brachial sphygmogram area	sq. mm/sq. meter body surface area
2. Brachial sphygmogram systolic amplitude	mm/sq. meter body surface area
3. Brachial sphygmogram obliquity angle	degrees
4. Tension period of cardiac cycle	seconds
5. Isovolumetric contraction period	"
6. Electromechanical lag	"
7. Total systole	"
8. Mechanical systole	"
9. Ejection period	"
10. Diastole	"
11. Cycle time	"
12. Pulse transmission velocity	meters/sec
13. Systolic blood pressure	mmHg
14. Diastolic blood pressure	mmHg
15. Physical Working Capacity$_{170}$	ft-lbs/lb body weight/min
16. Astrand-Rhyming VO_2	ml/kg/min
17. Sum of 6 skinfold thicknesses	mm
18. Sum of 10 skinfold thicknesses	mm
19. Fat surplus*	arbitrary units
20. Expanded chest — abdominal girth	inches
21. Reciprocal ponderal index	height/cube root of weight
22. Predicted specific gravity	gms/ml
23. Age	years
24. Sum of 4 muscle girths	inches
25. Calories in breakfast	Calories
26. Saturated fat in breakfast	gms
27. % saturated fat in breakfast	%
28. Chest skinfold	mm
29. Juxta-nipple skinfold	mm
30. Dorsum of arm skinfold	mm
31. Subscapular skinfold	mm
32. Cheek skinfold	mm
33. Abdominal skinfold	mm
34. Hip skinfold	mm
35. Gluteal skinfold	mm
36. Front thigh skinfold	mm
37. Rear thigh skinfold	mm

*"Fat surplus" is proposed as a tentative term to represent the sum of 6 skinfold thicknesses divided by endomorphy rating.

FIGURE 1
SIMULTANEOUS RECORDS

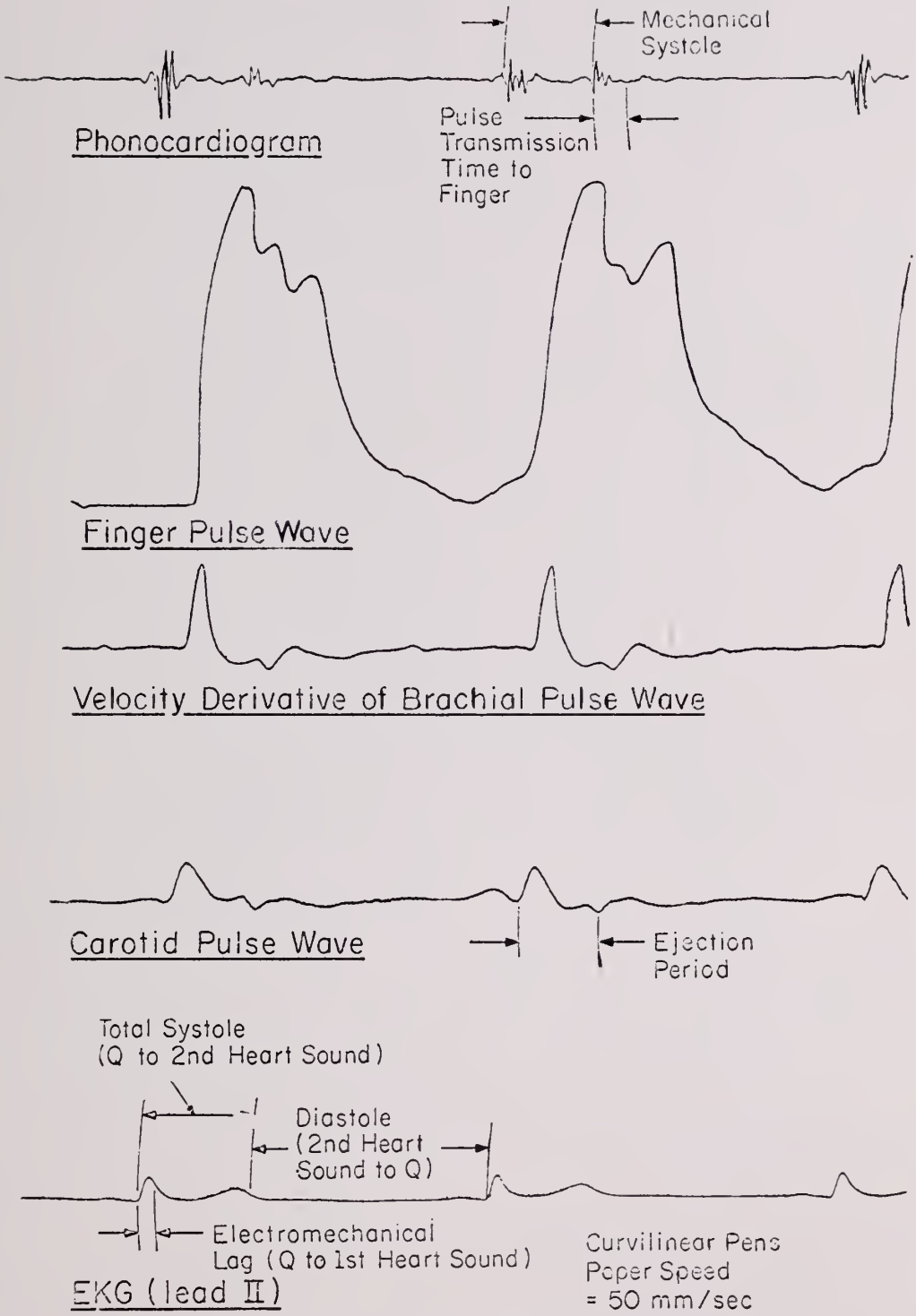

Figure 1. Simultaneous recordings for determination of cardiac time intervals.

through usage of Bowes and Church;[4] gms saturated fat was calculated by subtracting gms polyunsaturated fat from total fat gms, which makes for some error arising from the inclusion of monounsaturated fat in the saturated fat value. The skinfold thicknesses were measured with a Lange‡ skinfold caliper factory-calibrated to give a constant pressure of 10 gm/sq mm of jaw surface throughout the range of opening; the calibration was not checked by the author.

Statistical Treatment. An IBM 7094 computer was used to obtain the means, standard deviations, intercorrelational matrix, distribution analyses, and step-wise multiple regression to predict serum cholesterol (Hycel values). Skewed distributions were normalized by conversion to natural logarithms and re-entered into the step-wise program. Each of the zero-order correlations in the final prediction equation was tested for linearity of regression according to the method of McNemar (15, p. 275-281).

‡Cambridge Scientific Industries, Inc., 19 Poplar St., Cambridge, Maryland.

The following statistics were calculated for each laboratory's serum cholesterol determinations:

1) test-retest reliability on 9 subjects (r_{11})

2) standard error of measurement ($SE_{meas.}$)

3) standard error of the method ($SE_{meth.}$), calculated thusly:

$$SE_{meth.} = \frac{S_{a1 - a2}}{\sqrt{n - 1}} \quad , \quad \text{where}$$

$s_{a1 - a2}$ = standard deviation of the differences between analysis #1 and analysis #2 for 12 reproducibility samples

n = number of differences

4) mean and standard deviation of the differences between analysis #1 and analysis #2 for 12 reproducibility samples

Test-retest reliabilities for the independent variables were computed on 9 or more subjects.

Results

The reliabilities and correlation of each test with serum cholesterol (with significance levels indicated) are presented in Table 2.

The raw score multiple regression equation to predict serum cholesterol was:

$$\text{Log}_e X_o = 5.0005 - .1508 \text{ Log}_e X_1 - .2734 \text{ Log}_e X_2 + .4458 \text{ Log}_e X_3$$

$$-.0209 \text{ Log}_e X_4 + 5.7914 \text{ Log}_e X_5 \text{ , where}$$

X_0 = serum cholesterol, mg%

X_1 = PWC_{170}, ft-lbs/lb/min.

X_2 = fat surplus, mm/endomorphy rating

X_3 = age, years

X_4 = saturated fat in breakfast, gms.

X_5 = predicted specific gravity, gms/ml.

Table 2

RELIABILITIES AND CORRELATION OF EACH VARIABLE WITH SERUM CHOLESTEROL

	VARIABLE	rII	r with Cholesterol	Significance
1.	Brachial sphygmogram area	.48	.016	--
2.	Brachial sphygmogram systolic amplitude	.57	.050	--
3.	Brachial sphygmogram obliquity angle	.68	.114	--
4.	Tension period	—.04	.098	--
5.	Isovolumetric contraction	.15	.106	--
6.	Electromechanical lag	.20	—.013	--
7.	Total systole	.54	.009	--
8.	Mechanical systole	.67	.011	--
9.	Ejection period	.86	—.052	--
10.	Diastole	.87	—.206	--
11.	Cycle time	.85	—.183	--
12.	Pulse transmission velocity	.40	.253	.10
13.	Systolic blood pressure	.84	.098	--
14.	Diastolic blood pressure	.40	.187	--
15.	PWC_{170}	.83	—.274	.05
16.	Astrand-Rhyming VO_2	.92	—.281	.05
17.	Sum of 6 skinfolds	.94	—.052	--
18.	Sum of 10 skinfolds	.95	.056	--
19.	Fat surplus	.61	—.292	.05
20.	Exp. chest - abdom. girth	.87	—.020	--
21.	Reciprocal ponderal index	.98	—.342	.05
22.	Predicted specific gravity	.99	—.315	.05
23.	Age	1.00	.450	.01
24.	Sum of 4 muscle girths	.99	.261	.10
25.	Calories in breakfast	--	—.027	--
26.	Gms. saturates in breakfast	--	—.091	--
27.	% saturated fat in breakfast	--	.035	--
28.	Chest skinfold	.84	.221	--
29.	Juxta-nipple skinfold	.83	.261	.10
30.	Dorsum of arm skinfold	.99	—.161	--
31.	Subscapular skinfold	.97	.390	.01
32.	Cheek skinfold	.93	.009	--
33.	Abdominal skinfold	.93	—.024	--
34.	Hip skinfold	.86	.019	--
35.	Gluteal skinfold	.83	—.020	--
36.	Front thigh skinfold	.95	—.150	--
37.	Rear thigh skinfold	.86	—.133	--

Multiple R = .611, $SE^{EST.}$ = $antilog^{E}$ .19366

A comparison of the actual cholesterol values with the predicted values yielded an average difference of $antilog^{E}$ .13675, a figure considerably lower than the standard error of estimate. Table 3 shows the percent net contribution of each variable toward the prediction, calculated by dividing each Beta squared by the sum of Betas squared.

Table 4 presents the intercorrelational matrix for the variables in the prediction equation. When tested for linearity of regression, all of the zero-order correlations with cholesterol (as shown in Table 4) yielded insignificant (.05 level) F ratios, meaning there was no evidence to indicate that the correlations were curvilinear.

The mean, standard deviation, range, reliability coefficient, $SE^{MEAS.}$, $SE^{METH.}$, mean

Table 3

PERCENT RELATIVE CONTRIBUTIONS TO PREDICTION

	VARIABLE	Beta	Beta2	% Contribution to Prediction
X_1	PWC_{170}	—.2074	.043	6.23%
X_2	Fat surplus	.3594	.129	18.69%
X_3	Age	.6368	.407	58.86%
X_4	Gms. saturated fat	—.1178	.014	2.03%
X_5	Predicted specific grav.	.3125	.098	14.19%
			.691	100.00%

reproducibility difference, and standard deviation of the reproducibility difference for the Hycel and Unitest serum cholesterol values are presented in Table 5. The correlation between the Hycel and Unitest values was .939.

Discussion

A negative correlation was obtained between fat surplus (sum of 6 skinfolds divided by endomorphy rating) and serum cholesterol; this may have been due to the influence of endomorphy rating (as the denominator) on the fat surplus value, in view of the significant (.05 level) correlations found by Tanner[17] and Gertler, Garn, and Sprague[11] of .39 and .26, respectively, between serum cholesterol and endomorphy rating.

The significant correlations (.05 level) between serum cholesterol and age, subscapular skinfold, and reciprocal ponderal index found herein were also found by Keys *et al*,[13] Tanner,[17] and Chapman and Massey,[6] respectively.

Table 4

INTERCORRELATIONAL MATRIX FOR VARIABLES IN PREDICTION EQUATION

	1	2	3	4	5
1. PWC_{170}					
2. Fat surplus	—.056				
3. Age	—.484	.057			
4. Gms. satur. fat	.049	.027	.349		
5. Pr. specific gr.	.765	—.011	—.690	—.135	
6. Serum cholesterol	—.263	—.318	.460	.042	—.265

It is realized that chance correlations could possibly have occurred in the present study, in spite of the 1.38 ratio of subjects to independent variables.

Thus far no investigator has tried to predict serum cholesterol from chronic dietary patterns, yet inter-individual and intra-individual studies have suggested that serum cholesterol may be a function of habitual saturated fat consumption[2] and/or positive caloric balance.[14]

The means for the Hycel and Unitest methods (see Table 5) would seem to question the acceptance of 150-250 mg% as the absolute normal range.[12]

Conclusions

Within the limits of this study, the following conclusions seem warranted:

1. A relatively simple but crude estimate of serum cholesterol can be made by predicting from PWC_{170}, fat surplus (sum of 6 skinfolds/endomorphy rating), age, gms saturated fat in breakfast, and predicted specific gravity ($R = .611$, $SE^{EST.} = \text{antilog}^{E}\ .19366$).
2. Serum cholesterol can be reliably and reproducibly measured by either the Hycel or Unitest method.
3. Serum cholesterol is significantly correlated (.05 level) with age, sum of 6 skinfolds/endomorphy rating, predicted specific gravity, PWC_{170}, Astrand-Rhyming prediction of maximal oxygen intake, reciprocal ponderal index, and subscapular skinfold thickness.

TABLE 5

DESCRIPTION OF HYCEL AND UNITEST SERUM CHOLESTEROL DATA

(all statistics expressed in mg% except r_{11})

	X	s	range	r_{11}	SE_{meas}	SE_{meth}	D_{a1-a2}	s_{a1-a2}
Hycel	245.2	63.90	144-450	.97	9.90	3.04	5.50	10.10
Unitest	250.2	64.70	155-448	.98	8.09	1.22	3.42	4.06

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Radiology Case of the Month

JOSEPH C. ANDERSON, M.D.
Radiology Department
University of Nebraska School of Medicine

This 71 year old white male was admitted to the hospital because of an abdominal mass found by his family physician during physical examination. The patient had been unaware of the mass and was asymptomatic except for urinary tract symptoms related to an enlarged prostate. There had been no weight loss. All laboratory studies were within the range of normal. A supine abdominal film during barium examination of the small bowel is shown in Figure one.

Figure 1

WHAT IS YOUR DIAGNOSIS:

1. Pancreatic pseudocyst
2. Lymphosarcoma of the small intestine
3. Regional enteritis
4. Mesenteric cyst
5. Adenocarcinoma of the left kidney

ANSWER:

Lymphosarcoma of the small intestine, predominantly mesenteric invasive form. Figure one is a 30-minute film from the small bowel series showing separation of proximal jejunal loops by a large extrinsic mass.

Approximately 40 percent of primary malignant neoplasms of the small intestine are lymphomas.[1] Anorexia, weakness, weight loss, a palpable abdominal mass, anemia and abdominal pain are the clinical features most often associated with small bowel lymphosarcoma. These neoplasms usually do not obstruct the intestinal lumen and therefore may be very large before the patient consults a physician. The roentgen characteristics of this tumor depend upon the direction of growth.[1] Since a lymphosarcoma may arise in the lymphoid tissue of the mucosa or submucosa, it usually will extend along the long axis of the bowel and will have its origin in multiple sites.[2] The direction of growth may be toward the lumen, toward the serosa or in both directions.[1]

Marshak and Linder have classified the roentgenologic changes of small intestinal lymphosarcoma into five categories:[2] (1)

Figure 2

Figure 3

multiple nodular defects, (2) infiltrating form, (3) polypoid form, (4) endo-exoenteric form, and (5) invasive form of the mesentery.

Our case presented in this communication can be classified as the predominantly invasive mesentery type. The bulk of the tumor grew away from the lumen forming a huge extraluminal mass. Figure two shows how the mesenteric mass appeared at surgery. The adjacent jejunal wall was thickened and the neoplasm was found to extend to the root of the superior mesenteric artery. Figure three is a spot roentgenogram of the involved jejunum showing spiculization of the bowel wall margin and thickened submucosa secondary to invasion of the intestinal wall.

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Turn Back the Clock

We have all of us had interesting things happen in our medical practice: I mean puzzling cases, curious events, smile-provoking situations, miraculous cures that we recall fondly. I mean happy happenings, difficult diagnoses, and heart-rending scenes, stories that have been so stamped in our memory that we can never forget them, things that will fascinate readers.

Some of these will have happened during internship or residency, and many over the long years of practice.

I will modestly begin with a story of my own, in this issue of the Journal; it is called "I Remember."

And I invite our readers to send theirs in; I am sure they will do better.

Mark your story: "For Publication." Galley proofs are not necessary, and will not be sent. Remember your internship, the early days of practice, the unusual case, the life you saved?

Turn back the clock; read "I Remember," and send yours in.

—F.C.

Between Cases

Quote Unquote.
Psychiatry, I suppose, is the ultimate wizardry.
Bazelon

The Consultation
Our doctor had called in another, I never had seen him before.
Tennyson: In the Children's Hospital

Statistics.
The optic nerve contains 1,200,000 nerve fibers.

A Four-Letter Word.
PSRO

Department of Synonyms.
Flower of heaven: smallpox, in old Chinese literature.

Words We Can Do Without.
Overall, probative, dialogue, knowledgeable, substantive, structuring.

Quote Unquote.
From babies without love, they become adults full of hate.
Spitz

On Diagnosis.
He was seen by several consultants, including a neurologist who felt that the patient had essentially pain of an undetermined etiology.

On Finance.
The whole bill for health care in the U.S. is now more than 80 billion dollars, or approximately $375 per person per year.

On Reading.
Woodrow Wilson, whose first name was Thomas, learned to read when he was 11.

What It Means.
Alopecia: fox (a mange-like disease in foxes).
Sacrum: sacred.

On Mental Retardation.
Edison and Einstein were thought, when young, to be mentally dull.

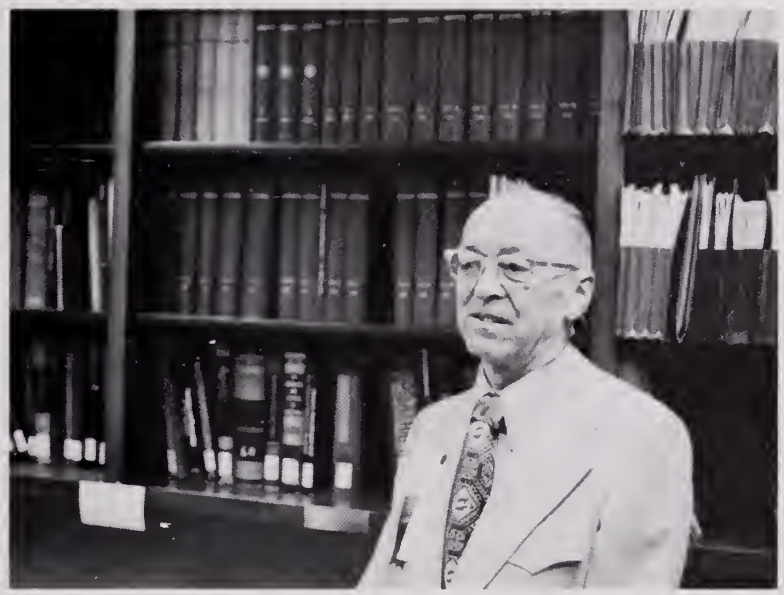
On Polls.
Only 3 percent of U.S. adults consider health care to be a top priority national problem.

On Happiness.
The master word is work.
Osler

Quote Unquote.
Deprivation of motivation is the greatest mental tragedy because it destroys all guidelines.
Selye

—F.C.

Picture Gallery



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JANUARY 1944 - JUNE 1973

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FRANK COLE, M.D.
LINCOLN, NEBRASKA

FRANK P. STONE
Study Area

Doctor John D. Coe presenting plaque to Doctor Earl F. Leininger for distinguished service as Delegate and Alternate Delegate to the AMA.

AMA Board of Trustee member, Doctor Max H. Parrott, addressing the House of Delegates.

Nominating Committee Chairman, James G. Carlson, presenting the report of the committee to the House of Delegates.

The NMA House of Delegates in Session.

Doctor Ralph L. Wicks, President of the Iowa Medical Society and Doctor John J. Regan, President of the Minnesota State Medical Association in attendance at the Annual Session.

NMA Past Presidents attending the House of Delegates Session (Doctors Harold S. Morgan, O. A. Kostal, R. E. Garlinghouse, John D. Coe, Frank H. Tanner, and J. Whitney Kelley.)

NMA Board of Councilors in session.

NMA Board of Councilors in session.

NMA Board of Councilors in session.

Doctor Maurice M. Steinberg presiding at the Annual Distinguished Luncheon.

Mr. Victor Riesel speaking at the Annual Distinguished Luncheon.

Annual Distinguished Luncheon.

Woman's Auxiliary

NEBRASKA MEDICAL ASSOCIATION ANNUAL STATE CONVENTION MEETING

April 29, 1974

REPORT: RESOLUTIONS COMMITTEE

WHEREAS, we consider it fitting and proper to express our thanks to all who have contributed to the success of this convention and the accomplishments of our past year's work; therefore be it

RESOLVED, that we, the members of the Woman's Auxiliary to the Nebraska Medical Association, extend our grateful thanks and appreciation to the officers and other members of the Executive Board of our organization, who have so ably carried on the business necessary for the proper functioning of the Auxiliary; and be it further

RESOLVED, that our thanks and appreciation go to the Woman's Auxiliary to the Omaha-Douglas County Medical Society, hostess to this forty-ninth Annual Meeting, for the welcome hospitality extended to all of us; be it further

RESOLVED, that we express particular gratitude to Mrs. Denham Harman, Convention chairman, and to all her committee chairmen, for their work and thoughtfulness in planning for our convenience and entertainment; and be it further

RESOLVED, that the Nebraska Medical Association be advised that we appreciate their leadership and assistance, that in particular Dr. John Coe, President of the Nebraska Medical Association, and the Advisory Committee be informed of our gratefulness for their help and guidance throughout the year; and be it further

RESOLVED, that Dr. Frank Cole, Editor of the Nebraska Medical Journal, Mrs. Robert Jones, Editor of the NEWSLETTER, Mr. Kenneth Neff, Executive Secretary of the Nebraska Medical Association, Mr. William Schellpeper, Assistant Executive Secretary, and the office assistants, and Susan Miller for her help in preparing materials and mailing the NEWSLETTER, be advised of our sincere thanks for the efficient way they have handled our Auxiliary News, and for their ready assistance whenever we have asked for it, and be it further

RESOLVED, that we express our thanks to Dr. Robert Sparks, Chancellor of the University of Nebraska Medical School and the Faculty Women's Club, the Omaha World Herald, the Nebraska Clothing Co., and to television station KMTV, and be it further

RESOLVED, that we pledge our loyalty and devotion to the Woman's Auxiliary to the Nebraska Medical Association; that we continue to be faithful in supporting its activities; promoting its projects and protecting its reputation and high ideals, and be it finally

RESOLVED, that these resolutions be published in the NEBRASKA MEDICAL JOURNAL.

Respectfully submitted,

Mrs. Chester H. Farrell
Chairman.

Our Medical Schools

Appointments at Creighton

Joseph M. Holthaus, M.D., Dean, Creighton University School of Medicine announced the following promotions and appointments:

APPOINTMENTS

Leon G. Benschoter, M.S., Assistant Professor of Biomedical Communications

Mary Jane Moran, M.A., Research Associate in Preventive Medicine & Public Health

Morton D. Maser, Ph.D., Associate Professor of Pathology

John H. Mattox, M.D., Assistant Professor of Obstetrics and Gynecology

Shien Tsai, Ph.D., Instructor in Pathology

Elizabeth J. Bergstrom, M.S., Assistant Instructor in Medical Microbiology

Rita M. Kessler, B.S.M.T., Assistant Instructor in Medical Microbiology

James G. Cummins, M.D., Clinical Instructor in Obstetrics & Gynecology

Felix L. Rodriquez, M.D., Associate Professor of Pathology

Sueng-Koo Lee, M.D., Assistant Professor of Pathology

Paul F. Reichstadt, M.D., Assistant Professor of Family Practice

John D. Dunn, M.D., Instructor in Family Practice

John F. Collins, M.D., Assistant Professor of Family Practice

James H. Whicker, M.D., Clinical Instructor in Otolaryngology

Todd J. Bruett, M.S., Clinical Instructor in Psychiatry & Neurology

PROMOTIONS

John T. Elder, Ph.D., to Professor of Physiology/Pharmacology

Joseph M. Holthaus, M.D., to Professor of Medicine

Michael J. Weaver, M.D., to Assistant Clinical Professor of Medicine

Syed M. Mohiuddin, M.D., to Associate Professor of Medicine

Richard D. Schultz, M.D., to Associate Professor of Surgery

Andrew L. Hahn, M.D., to Professor of Medicine

Robert E. Burch, M.D., to Professor of Medicine

Michael J. Haller, M.D., to Associate Clinical Professor of Family Practice

Francis R. Fitzmaurice, M.D., to Professor of Pediatrics

U of N appoints

Seven new faculty members at the University of Nebraska Medical Center were approved by the Board of Regents recently.

Dr. David Clayson was named deputy director of the Eppley Institute for Cancer Research, effective in August.

Dr. Clayson's *Chemical Carcinogenesis* is considered one of the most authoritative texts in the field by cancer researchers.

Dr. Jagdish Teja was named professor of psychiatry and clinical director of adult inpatient service at the Nebraska Psychiatric Institute.

Dr. Rose Faithe was named associate professor of family practice. Dr. Faithe's responsibility will be at the W Street Clinic. She has been in private practice in Nebraska and South Dakota since her graduation from the College of Medicine in 1964.

Dr. Faithe is a graduate of the University of Omaha and Creighton University School of Law.

Dr. Patricia Forsman was named assistant professor of pediatrics. She has been working in endocrinology under a fellowship at the Pittsburgh, Pa., Children's Hospital since completing her residency in pediatrics at the Medical Center last year.

Dr. David Goldberg is a new assistant professor of psychiatry. He will be respon-

sible for adult outpatient service at the Nebraska Psychiatric Institute.

Dr. Martha Kleinberg was chosen assistant professor of pediatrics and fourth-year fellow in cardiology. She will be on the staff of the Omaha Health Center at 3645 Larimore.

Dr. Robert Wigton was named assistant professor of internal medicine. He is completing a residency at the Medical Center and is a graduate of the College of Medicine.

News from Creighton

Dr. J. Raymond Johnson, Professor of Physiology and Pharmacology, was honored at Creighton's Commencement. He received the Dedicated Teacher Citation.

Dr. Harold N. Neu, Clinical Professor of Medicine, has been elevated to Professor Emeritus of Medicine. Dr. Neu was recognized at Commencement exercises.

Dr. Richard A. Ortez has been awarded a $23,922 research grant for studies of the role of cyclic adenosine 3', 5'-monophosphate in Bordetella pertussis induced histamine hypersensitivity. The grant is from the American Lung Association and the American Lung Association of Iowa.

Bristol Laboratories has awarded a $2,940 grant to Dr. Christine C. Sanders for evaluation of the susceptibility of ampicillin-resistant gram-negative bacilli to BL-P1654 and its kinetics of bactericidal activity against pseudomonas.

Dr. Robert Luby has received $11,000 from Ciba Pharmaceutical Company to participate in a dialog postpartum pain study. The Department of OB-Gyn has also received $10,740 from Ayerst Laboratories for the evaluation of PMB-400 for 25 patients.

Dr. Robert Townley received $6,000 from Dorsey Laboratories on behalf of the Wander Foundation. The money will be used to support a postdoctoral research fellow involved in studying certain immunological and pharmacological aspects of allergies.

I Remember

THE STUDENT AND THE WONDERFUL CASE

I was a senior medical student. Our group was assigned to a nearby teaching hospital, and we were to take histories and do physical examinations. The resident on the medical service told us which patients to see every day, and he had what is called a sense of humor.

Because one of the new patients happened to be a doctor himself, a hospital intern, in fact, who was to have a hernia repair the next day. Whereupon the resident assigned this patient to a fellow-student who was a friend of mine, and who was rather gullible, but he didn't tell my friend who the patient was. "Be very careful," he said. "He's a mental case, and he actually thinks he's a doctor." Now, not only was the resident careful not to tell the whole truth to my naive classmate, but he did not let the intern in on the joke, either. Maybe he forgot.

So the student spent all morning on this case, while the rest of us figured out what was going on, or were let in on the secret. And in the afternoon, he reported to the resident and to our little group.

It was a wonderful case, he thought. "He *really* believes he's a doctor," he said. "He was reading Boyd's Pathology when I came to see him!"

I have often thought of that delightful scene in the hospital room, and I wish I could have heard their conversation. And I always wondered what the patient thought of my friend.

—F.C.

President's Page

On Professional Responsibility and Medical Economics

Of the many factors of importance facing Nebraska medicine at the moment, none will be apt to affect the doctor-patient relationship quicker than economics. In all survey polls, the physician is regarded with the highest esteem by the public, as we have been through the years. Of the menacing factors to this relationship, I see none capable of greater or quicker disruption than the economic element.

We can truthfully point out the economic problems created in hospitals and elsewhere by our expanding technology and by the problems created by exorbitant demands by the public for the finest in medical accommodations (TV, carpets, electric beds, etc.) which in fact are not related to the quality of health care delivered or received. With persistant repetitive recitations we can continue our efforts at aborting, attenuating and ameliorating the politicians' programs. These we can do while at the same time maintaining the respect and confidence of our patients.

The point at issue is that, at this moment, we as physicians are faced with multiple economic pressures, even more than the general public, pressures which are bound to increase our charges. We are faced with the problems of fee adjustments as a result of the ending of Phase 4 restrictions. We are faced with general inflation and its attendant effects upon cost of supplies and labor as they affect our offices. In Nebraska we are faced with reassessment of a new economic scale for use in compensation cases. (The last time these fees were altered was 1965.) In all of these items the public can understand our position, providing that position is fair and justifiable.

Of most concern to me, however, is that we must maintain a defense against economic over-reacting to the various agencies and individuals, governmental and private, which we find to be so noxious. The pressures of governmental threats, of national health insurance, of various medical doom-sayers, of pressure-scare tactics including President Nixon's estimation of a 22% increase in physicians fees, are apt to create an atmosphere in which we may, in frustration, over-react.

We must continue as responsible citizens in a responsible profession to exercise a cautious restraint on fee increases. We cannot maintain a position of strength and the respect of our patients if we act injudiciously. Kindness, courtesy, consideration and economic fairness in dealing with our patients should continue to be keystones of our efforts in avoiding a loss of respect by the public and total governmental entrapment.

James H. Dunlap, M.D.

Integument!

Our skin—the human integument—covers us, defines us, protects us. But skin is subject to cuts, burns, abrasions. And infections. Neosporin Ointment fights infection by providing broad antibacterial action against susceptible skin invaders. It contains antibiotics that are rarely used systemically, reducing the risk of sensitization.

INDICATIONS: *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

NEOSPORIN® Ointment

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Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q.s. In tubes of 1 oz. and ½ oz. and 1/32 oz. (approx.) foil packets.

Wellcome

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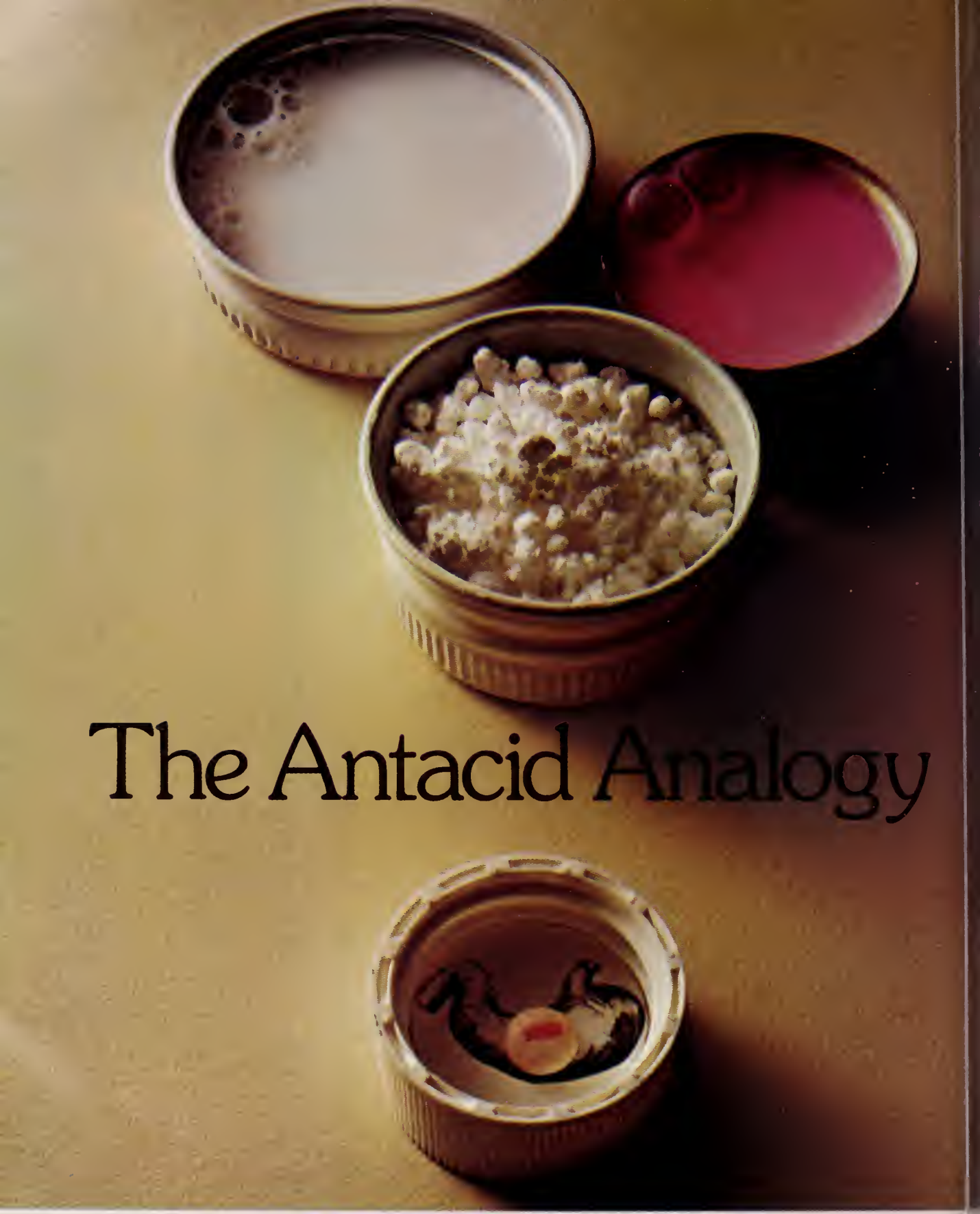

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution.

Fever and possibly heat stroke may occur due to anhidrosis.

In theory a curare-like action may occur, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiratio should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and thi possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidence by elderly males with prostatic hypertrophy, such patients should b advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions ma

Therapeutic comparisons in peptic ulcer.

Antacids have only one mode of action to relieve ulcer pain...

Pro-Banthine® has four.

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Antacids relieve ulcer pain by neutralizing gastric acid. This action is relatively short-lived and they have no other mode of action.

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Pro-Banthine suppresses gastric acid secretion. The antisecretory properties of Pro-Banthine are well established. By effectively blocking vagotonic impulses Pro-Banthine suppresses gastric secretion to reduce both total and free acid.

Pro-Banthine helps relieve pain. Pro-Banthine relieves ulcer pain by reducing gastric secretion and the motility and spasm of the gastrointestinal tract.

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Pro-Banthine activity lasts about six hours. The effect of a single therapeutic dose (15 mg.) of Pro-Banthine lasts about six hours.* Pro-Banthine P.A.®, the prolonged-acting form, is active from 8 to 12 hours. Thus Pro-Banthine may be used to suppress acid, spasm, and pain around the clock, even during the sleeping hours when antacids, to be effective, must be taken almost hourly.

*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

Pro-Banthine complements and enhances the action of antacids.

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occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

Pro-Banthine P.A.—Each tablet of Pro-Banthine P.A. (propantheline bromide) contains 30 mg. of the drug in the form of sustained-release or timed-release beads; on ingestion about half of the drug is released within an hour and the remainder continuously as earlier increments are metabolized. Thus the result is even, high-level anticholinergic activity maintained all day and all night in most patients with only two tablets daily. Some patients may require one tablet every eight hours.

The contraindications and precautions applicable to Pro-Banthine 15 mg. should be observed.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles and Single Unit Packages of 100 capsules.

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*Serum Potassium Level Drops During Long-Term Exercise, *Medical Tribune*, July 4, 1973.

†No implication that 'Dyazide' is useful in preventing K^+ loss in athletes is intended.

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MANY HYPERTENSIVE PATIENTS LOSE POTASSIUM†

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Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

SPARES THE HYPERTENSIVE PATIENT'S POTASSIUM AS IT LOWERS BLOOD PRESSURE.

Down Memory Lane

1. Goitre has received so much attention in recent years that it would almost seem that nothing new could be said about it.

2. Diarrhea like vomiting is only a symptom, yet when we stop to consider that approximately 1/3 of all the deaths occurring during the first year of life is due directly or indirectly to this one symptom, it is a condition which should receive the most serious consideration no matter how mild the case.

3. About fifteen years ago when the Roentgen ray was brought into use, it was accepted rather doubtfully and was employed only in very unusual and rare cases. Today, it is recognized as the one diagnostic assistant that cannot be dispensed with.

4. The conclusion is forced upon us that pelvic pain is a most unreliable guide in the diagnosis of diseases of women. Someone has said: "Pain is the greatest liar of them all."

5. Influenza. No effective vaccination for inoculation against this disease has been discovered.

6. The logical care of the infant in summer entails a greater effort to prevent the ill effects of over heating and over eating.

7. Operation in fracture cases should never be undertaken lightly and should be done only in cases where reduction cannot be maintained any other way.

8. A room has been contracted for by the year in St. Joseph's Hospital, Omaha, for the use of Veterans of the late war, and their dependents, who are unable to pay for hospital care.

9. She who knows, says it was noticeable that but few doctor's wives had bobbed hair.

10. Essayists at A.M.A. meetings should practice to speak louder.

Nebraska State Medical Journal
July, 1924

Welcome New Member

Richard A. Raymond, M.D.
Lynch, Nebraska 68746

WashingtoNotes

National health insurance (1)

With the exception of a possible last-minute catastrophe bill to the liking of both the Senate and the House, the prospects for a national health insurance (NHI) bill this year appear to be fading.

Senate Finance Committee Chairman Russell Long (D-La.), and other committee members heard AMA President Russell Roth, M.D., President-elect Malcolm Todd, M.D., and Ernest Livingstone, M.D., Chairman of the AMA Legislative Council, support the Medicredit measure.

"As the nation's largest association of actively practicing physicians, the ones who will be called upon to provide the professional services which are contemplated under any program which may be authorized by Congress, we feel that our viewpoints are extraordinarily important," Dr. Roth told the committee.

"If we are to meet the principal needs not only of the aged and the poor but of the vast middle income group, it would seem we must endeavor to provide basic coverage for medical service and if possible, add to this protection against ruinous catastrophic major medical expense (Senators Long and Abraham Ribicoff (D-Conn.), are sponsors of a catastrophic-only type NHI proposal).

"The catastrophic coverage should be adjusted to ability to pay, since it is obvious that an amount which could be easy for the well-to-do family to pay could be disastrous for the much larger group of middle and low-income individuals.

"We believe that the public will look with dismay on a financing mechanism which increases the Social Security tax by 4 percent, as with the Kennedy-Mills proposal.

"We have enthusiasm for the financing mechanism in the Medicredit bill which uses tax credits to minimize the number of dollars making a round trip to Washington as tax to return as a shrunken benefit, and which places the obligation to contribute their share on those who have the ability to pay all or part of their premium cost.

"In the case of National Health Insurance, we feel assured that if any part of the funding derives from Social Security taxes there would be a compulsion for Social Security control of the program.

"We are confident that the administration of the program will best be accomplished by existing private entities in the field. Federal involvement, while inescapable when dealing with federal tax dollars, should be kept minimal."

NHI (2)

First witness before the Senate Finance Committee hearing was HEW Secretary Casper Weinberger who urged that a NHI bill "should be the highest priority item in the closing months of this Congress." He expressed hope that the areas of disagreement between competing NHI proposals would not be found insurmountable.

The Secretary, however, criticized all of the competing proposals, but with special attention to the Mills-Kennedy and the Health Security bill of organized labor. "Both vest too much power with the federal government," Weinberger said.

Senator Hansen (R-Wyo.), said that when negotiating time arrives there should be strong consideration of the Medicredit bill which has 182 sponsors, including five members of the Finance Committee and 11 members of the House Ways and Means Committee.

Senator Hartke (D-Ind.), said Medicredit has more sponsors than all other NHI bills combined. Weinberger said he would keep that in mind while conferring with Congress.

Sen. Abraham Ribicoff (D-Conn.), said the Administration was being deceptive about the true costs of its program. He contended Weinberger is telling the American people they will have a $55 billion "free lunch."

NHI (3)

Meanwhile, on the House side of the Ways and Means Committee completed the second month of one-day-a-week hearings on NHI.

One day's hearing saw the following organizations testify before the powerful House Committee: Blue Cross Association, National Medical Association, American Osteopathic Society, National Council of Health Services, American Podiatry Association, National Council of Community Health Centers, Veterans of Foreign Wars, and Americans for Democratic Action.

Some sparks flew when Andrew Biemiller, director of the AFL-CIO's Department of Legislation, appeared in place of AFL-CIO president George Meany. Biemiller in effect took an all-or-nothing approach, insisting that unless a bill similar to the original Kennedy-Griffiths measure is approved it would be better to wait until next year.

More

Labor's stand drew criticism from committee members, some of whom stressed a theme that there is strong pressure for Congress to act this year especially on a catastrophic bill.

Biemiller said "if Mills-Kennedy is this committee's idea of a compromise, then I must say, in all candor, we will oppose it." Labor's strongest criticism came on the Long-Ribicoff bill. "It is not national health insurance, and does not pretend to be. It

would be therefore a catastrophe if the Congress enacted catastrophic insurance," said Biemiller.

A score of speakers rose to urge congressmen and senators to join them in backing Medicredit, which has more sponsors — 182 — than all other NHI proposals combined.

Rep. Jerry Pettis (R-Calif.), a member of Ways and Means said his colleagues should consider foreign national health systems:

He cited such cases as:

*In Sweden the per capita health care costs increased by 614 percent from 1950 to 1966 compared to 175 percent in the United States. Since 1960 medical costs in Sweden have increased almost 900 percent.

*In West Germany there is a serious maldistribution of medical personnel.

*Norway reports a shortage of practitioners.

*Hospital rates in Canada are higher and length of stay longer than in the U.S.

Rep. Peter Kyros (D-Maine), said Medicredit "goes right to the heart of the catastrophic problem." "No matter how large or small a family's income, its medical expenses would never exceed 10 percent of that income," said Kyros.

Rep. Robert Michel (R-Ill.), said Medicredit "meets the true test of any workable national health insurance plan — it provides access to high quality medical care to all Americans on the basis of sharing the cost in an equitable fashion. The poor would pay nothing. In a fair way, the better-off would pay on a sliding scale that reflected their income."

"Most importantly, this legislation would insure that no American would have to go bankrupt because of a catastrophic illness," said Michel.

PSRO

The Professional Standards Review Organization (PSRO) program is off to "an incredibly bad start" and encountering increasing physician resistance, the AMA has told Congress.

AMA President Russell Roth, M.D., testifying before the Senate Finance subcommittee on health, said 13 state medical societies have formally declared for repeal of the PSRO law and that 29 societies support a policy of amendment and/or repeal. (As of May 7, 1974).

During the two days of hearings, some 20 medical associations, state societies, and specialty groups testified their general misgivings with respect to the workability of the statute. Throughout the hearings Senator Wallace Bennett (R-Utah), stoutly defended PSRO — "I won't live long enough to see repeal of PSRO" — against, at times, shouting and hostile witnesses.

Coming Meetings

CRIPPLED CHILDREN'S CLINIC —
July 20 — Ogallala, Elks Lodge
July 27 — Chadron, Elks Lodge
August 3 — Scottsbluff, St. Mary's Hospital
August 10 — Norfolk, Elks Lodge

AMERICAN CANCER SOCIETY'S NATIONAL CONFERENCE ON GYNECOLOGIC CANCER; September 18-20, 1975, Marriott Hotel, Philadelphia, Pennsylvania.

AMERICAN CANCER SOCIETY — National Cancer Institute — Eighth National Cancer Conference; September 20-22, 1976, Regency Hyatt Hotel, Atlanta, Georgia.

NEBRASKA MEDICAL ASSOCIATION — Fall Session, October 3-5, 1974, Lincoln, Nebraska.

ANTIBIOTICS AND INFECTION — The Fifth Annual Meeting will be held at the University of Iowa Hospitals, Iowa City, on October 24th, 25th and 26th, 1974. Write to: Dr. Ian M. Smith, Department of Medicine, University of Iowa Hospitals and Clinics, Iowa City, Iowa 52242.

OMAHA MID-WEST CLINICAL SOCIETY — 42nd Annual Postgraduate Assembly, November 11, 12, and 13, 1974, Omaha Hilton Hotel. Write to: (Mrs.) Mary E. Pilloud, Executive Secretary, 1040 Medical Arts Building, Omaha, Nebraska 68102.

AMERICAN ASSOCIATION FOR CLINICAL IMMUNOLOGY AND ALLERGY — Annual Meeting; Pier 66, Ft. Lauderdale, Florida, November 21-24, 1974. Write to: John L. Dewey, M.D., P. O. Box 912, DTS, Omaha, Nebraska 68101.

AMERICAN CANCER SOCIETY — National Cancer Institute — National Conference on Advances in Cancer Management; Part I, Treatment and Rehabilitation, November 25-27, 1974, Waldorf-Astoria Hotel, New York City.

AMERICAN MEDICAL ASSOCIATION — 28th Clinical Convention, November 30-December 4, 1974, Portland, Oregon.

NEBRASKA MEDICAL ASSOCIATION — Annual Session, April 27-30, 1975, Lincoln, Nebraska.

AMERICAN CANCER SOCIETY — National Cancer Institute — National Conference on Advances in Cancer Management; Part II, Detection and Diagnosis, May 1-3, 1975, The Denver Hilton, Denver, Colorado.

AMERICAN MEDICAL ASSOCIATION — Annual Convention, June 15-19, 1975, Atlantic City, New Jersey.

Medicinews

TV grant by VA to Creighton

Creighton University Biomedical Communications Center has received a Veterans Administration grant of nearly 108 thousand dollars. Leon Benschoter, Director of the Biomedical Communications Center, said the funds will be used for new equipment and the continued operation of closed circuit television studios. The studios, located on the fifth floor of the Faculty Building at Saint Joseph Hospital, link Creighton University to Veterans Administration Hospitals in Omaha, Lincoln, and Grand Island and to facilities at the University of Nebraska Medical Center and Nebraska Psychiatric Institute.

Creighton will originate programs from its studios and will join other facilities in two-way medical conferences.

National health insurance

NHI featured prominently in the news with a Presidential radio address and hearings in both Houses of Congress. HEW Secretary Caspar W. Weinberger, appearing before the Senate Finance Committee, again urged the passage of the Administration's National Health Insurance proposal. The testimony centered on the cost-control, restructuring plans and benefit features of CHIP. Senator Hartke (D-Ind.), and six public witnesses testified May 22. Senator Hartke urged passage of S. 444, the Medicredit bill and strongly attacked financing mechanisms using the "regressive" payroll taxes. The Social Security tax simply cannot be afforded, Senator Hartke asserted.

Spokesmen for the AMA urged the Senate Finance Committee recently, to endorse S. 444, the AMA developed Medicredit bill. Appearing on behalf of the Association were Russell B. Roth, M.D., AMA President; Malcolm C. Todd, M.D., President-Elect; and Ernest T. Livingstone, M.D., Chairman of the Council on Legislation. Dr. Roth said that the initial focus of any national health insurance program should be the benefit structure. He called for a broad scope of benefits coupled with coverage for the catastrophic expenses of long-term illnesses and urged that catastrophic coverage be related to the ability to pay. Under such an approach, insurance coverage would operate at the level of need, he said, and a broad scope of benefits could be provided.

Leonard Woodcock, President of the United Auto Workers and Chairman of the Health Security Action Council, continued to press for passage of the Health Security Act, S. 3, attacking the Administration bill as "private sickness insurance, not national health insurance." Carlton Williams, DDS, President of the American Dental Association, asking that the existing private health care system not be dismantled, praised the provisions of the Medicredit bill. The Finance Committee has postponed further hearings on NHI.

Drug hearings

The Senate Health Subcommittee heard testimony regarding the Drug Utilization Improvement Act, S. 3441 and the Omnibus Drug Amendments, S. 966. The legislation pending before the Subcommittee deals with various aspects of the distribution of drug products, the teaching of clinical pharmacology, and the evaluation and control of drug prescribing.

Charles C. Edwards, M.D., Assistant Secretary for Health, testifying on behalf of the Administration, opposed the creation of a national center for clinical pharmacology stating that "present organizational arrangements are adequate to assure appropriate attention of pharmacological issues." He supported increased emphasis on clinical pharmacology and therapeutics in medical schools but cautioned that such training must be integrated into the general medical school curriculum. Dr. Edwards opposed the concept of a federal drug formulary but stated that the Administration would not object to the development of a drug compendium.

With respect to proposals which would make the FDA responsible for drug testing, he objected to the principle of disconnecting all drug testing and investigation from the drug industry. Under such a system he said, "FDA would, in effect, be cast in a role of a drug sponsor. The public would be deprived of the benefit of FDA impartial review of data on drugs."

Medicare

Final regulations limiting payments to Medicare providers for services to beneficiaries of the Federal health insurance program have been announced by HEW Secretary Caspar W. Weinberger.

The regulations implement a provision in the 1972 Social Security Amendments holding reimbursement to Medicare providers to the lesser of the reasonable cost of the services or the customary charges to the general public for such services. The provision is effective for services in Medicare cost reporting periods beginning after December 31, 1973.

Under the regulations, public providers — those operated by Federal, State, or local government agencies — will be reimbursed on the basis of their reasonable costs if they render services to Medicare beneficiaries free of charge or at a nominal charge. The regulations define "nominal" as charges that would, in the aggregate, recover less than one-half of the reasonable costs of the services for which they are imposed.

The regulations also give providers an opportunity to recover the difference between reasonable costs and customary charges arising from miscalculation of anticipated costs and charges. Providers generally will be allowed to carry forward costs in excess of charges for reimbursement for two succeeding Medicare reporting periods. The carry-over period for new providers extends to five succeeding reporting periods, in recognition of the possibility that new providers might experience costs in excess of charges until their operations reach a point where they are operating at normal occupancy levels.

The proposal was modified by moving forward the effective date to apply to Medicare cost reporting periods beginning after December 31, 1973, rather than December 31, 1972, to assure that providers would not suffer undue hardship under the new rules. The proposal was also changed to indicate that provider's Medicare reimbursable costs and charges would be compared to each other on an aggregate basis, without regard to whether the related services were rendered under Part A and Part B of the Medicare program.

Health manpower

Senator Kennedy (D-Mass.), has introduced two proposals to continue federal assistance in the area of medical education. They are S. 3585, The Health Professions Educational Assistance Act of 1974 and S. 3586 The Nurse Training Act of 1974. Existing authorities are scheduled to expire this June 30. In his introductory remarks Senator Kennedy placed particular emphasis upon problems of maldistribution of manpower both by area and by medical specialty. He further noted the extent of reliance upon foreign medical graduates. Under the bill virtually all medical school graduates would be obligated to two years of service in manpower shortage areas. It would further require periodic relicensure of physicians and would introduce nationwide licensure standards. The measure is also intended to reduce the number of foreign medical graduates practicing in this country. Students receiving federal assistance during their education would be required to serve in shortage areas, and professional schools would incur reduced federal support for every student who refuses to serve for the two year period. With respect to the allocation of medical specialties, legislation would require the Secretary of HEW to certify all residency programs. It is suggested that this system would direct more physicians into primary care fields as opposed to other specialties found by the Secretary to have adequate or excessive manpower.

Loan forgiveness for students receiving aid under the program would be 50% for the first year and 50% for the second year of service in shortage areas. Existing law

provides for a maximum loan forgiveness of 85% over a three-year period. Capitation grants to schools of the health professions, including schools of public health would be continued. These grants would be equal to 1/3 of the net educational cost of training a student as determined by an Institute of Medical Study. No school would be eligible for these capitation grants unless all enrollees agreed to serve in the National Health Service Corps or in a shortage area. The schools would also be required to maintain at least existing enrollment levels. In addition, schools of medicine, osteopathy, and dentistry would be required to train "physician extenders" or "expanded duty dental auxiliaries." Grants would be provided to medical schools for the training of American citizens transferring from foreign medical schools. Such funds would be directed toward identifying educational deficiencies of such students and preparing them for licensure examinations.

The Secretary of HEW would be required to develop national standards of licensure of all physicians and dentists who wish to practice in the United States. A national examination would be prepared and relicensure would be required every six years.

SCHEDULE OF UPCOMING NCME PROGRAMS

July 15 - August 11

SNAKEBITE, with Findlay E. Russell, M.D.

SKIN TESTING FOR TB, with John A. Crocco, M.D.

PARASITIC INFESTATION: LOOK FOR LICE, with Silas E. O'Quinn, M.D.

August 12 - September 8

RECEPTOR DRUGS: TIME BORROWERS IN SHOCK, with Leon I. Goldberg, M.D.

LOCAL ANESTHESIA: THREE EFFECTIVE TECHNIQUES, with William C. North, M.D.

THE PROBLEM PELVIC, with Phillip Sarrel, M.D.

Books

Retreat From Sanity, by Malcolm B. Bowers, Jr.; 245 pages; $8.95 hardbound; published 1974 by Human Sciences Press, division of Behavioral Publications, New York, N.Y.

The author is an M.D., I am happy to say, and is Chief of Psychiatry at the Yale-New Haven Hospital and Associate Professor of Psychiatry at Yale University School of Medicine.

What does it feel like to experience psychosis, to "go crazy?" These are stories, told about people, and told by people, about psychosis associated with pregnancy, drug use, heterosexual rejection, and so on. There are references, and the book has an index.

It's like a whodunit, it's interesting enough to read and enjoy, but it's serious and well written.

—F.C.

"Is Marriage Necessary?," by Lawrence Casler; 249 pages; $8.95 hardbound; published 1974 by Human Sciences Press, division of Behavioral Publications, New York, N.Y.

The author is a Ph.D. and has studied at Harvard and Columbia; he is Professor of Psychology in the State University of New York at Geneseo.

There is an Afterward by Albert Ellis, Ph.D. There is a bibliography, and author index, and a subject index, all of which I like.

Do children need love? Is marriage as bad as some think it is? Is it becoming obsolescent? What are the alternatives to marriage? Is marriage for everybody? What is the state of present-day marriage? Read this book and find out. Find out the author's opinions, anyway. He thinks it's a social disease.

—F.C.

Books received

The Practice of Clinical Casework, by Gertrude Sackheim, M.S., A.C.S.W.; 214 pages; $12.95 hardbound; published 1974 by Behavioral Publications, New York, N.Y.

The Group As Agent of Change, edited by Alfred Jacobs and Wilford W. Spradlin; 463 pages; 15 by 23 cm (6 by 9 in); $19.95 hardbound, $9.95; paperbound; published 1974 by Behavioral Publications, New York, N.Y.

Helping Skills: A Basic Training Program; by Steven J. Danish and Allen L. Hauer; 62 page manual, 122 page workbook; $4.95 workbook, 1 manual included; published 1973 by Behavioral Publications, New York, N.Y.

Reports of Officers, Delegates and Committees, Annual Session

April 28, 29 and May 1, 1974

(These reports appear as originally submitted. For the House of Delegates deliberations, possible changes, and final action, refer to the minutes which follow these reports).

REPORT OF DELEGATE TO AMERICAN MEDICAL ASSOCIATION, CLINICAL MEETING

REFERENCE COMMITTEE CONSTITUTION AND BY-LAWS

Report A, Co. Const. & Bylaws:

Limits term of trustees to two full terms of three years each. Not adopted.

Report B, Co. Const. & Bylaws:

On representation of specialty societies in the House of Delegates (also Resolution 3, Nebraska; opposition to Report B). The entire matter was referred to the Council on Constitution and Bylaws for further study and a hearing in June, 1974.

Report H, Co. Const. & Bylaws:

This calls for a review of the implementation of Quinn Committee report. This was adopted.

Report D, Co. Const. & Bylaws:

This calls for a change in the terms of the members of the Council on Medical Education and the Council on Medical Service from five years to three years with a maximum of three terms. This was approved.

Report E, Co. On Const. & Bylaws:

No changes in present methods of nominating members to a Council, but when a vacancy on any of the Councils occur, it should be given wide publicity before the convention. The Council on Constitution and Bylaws should study the possible creation of a nominating committee of the House of Delegates. Adopted.

Resolutions 2 & 9:

Calls for the election of Trustees at large. These were adopted and referred to the Constitution and Bylaws Committee for appropriate wording and subsequent action by the House.

REFERENCE COMMITTEE A

Report D, Co. on Med. Serv., and Resolutions 41, 51 & 53:

All of these, in general, call for preservation of confidentiality of medical records. The Council on Medical Service and the Council on Legislation was requested to keep the House informed of their efforts to achieve this goal. Adopted.

Report B, Co. on Med. Serv.:

This report is in response to Aetna Life and Casualty surgical predetermination form as interference with the practice of medicine. Aetna stated that it would not be offered to new accounts. HOUSE AGAIN REMINDS PHYSICIANS OF THE MANIFEST SUPERIORITIES OF DIRECT BILLING AND THE PROTECTION IT OFFERS FOR BOTH THE PATIENT AND THE PHYSICIAN AGAINST UNDESIRABLE INTERFERENCE FROM THIRD PARTIES. Adopted.

Report J, Co. on Med. Serv.:

On renal dialysis, reimbursement under Medicare, and Resolutions 38, 65, 66 & 70. Report J was a progress report which was adopted. The Resolutions were referred to the Council for their guidance.

Report A, Bd. of Tr.:

Activities regarding PSRO, progress report. This was adopted.

Report EE, Bd. of Tr. and Co. on Med. Serv.:

AMA policy on PSRO and Resolutions 11, 13, 29, 31, 43, 47, 57, 58 & 62. (Most of the resolutions call for repeal of PSRO).

Report EE from the Trustees calls for continuation of the existing policy of cooperation with government in the implementation of PSRO and opposition to repeal because this route was politically not viable. From the floor of the House an amendment was offered which reaffirmed the principle of peer review rather than professional review (government review) with the major thrust of the amendment calling for repeal of PSRO. The Amendment was sponsored by California, Illinois, Michigan, Kentucky, Louisiana, and New York. Both the amendment and Report EE were adopted. This complex problem was brought up as the last order of business and unfortunately some of the conflicts of statements in Report EE and the amendment were not ironed out, thus leaving the action in a state of mild ambivalence. However, the amendment was passed without a dissenting vote and it can be accurately reported that those who voted in favor of the amendment, were convinced that they were voting for **immediate action to seek repeal of PSRO.**

Res. 12 and 36:

Call for Judicial Council to study potential conflicts between PSRO and the principles of medical ethics. Resolution 12 was referred to the Judicial Council. Resolution 36, since it also involved constitutional rights was not adopted.

Res. 37 and 45:

Calls for the AMA to develop information on alternatives to PSRO. The House adopted a substitute resolution calling for the profession to remain firmly committed to the principles of peer review (not professional government review) and that each hospital medical staff continue to develop its own peer review in order to prove that objective review of quality and utilization does take place.

Res. 59:

Resolution 59 calls for a moratorium on implementation of Section 249F, Public Law 92-603. The House adopted an amended resolution which asks the AMA to seek a moratorium in asking that the law be tested for two years in an experimental area.

REFERENCE COMMITTEE B

Report V, Bd. of Tr.:

This has to do with medical device legislation. The Board of Trustees had authorized testimony in basic support of the Federal Medical Device legislation, HR 9984. Since it was House policy to oppose such legislation, the House was asked to support the Board's action. The report was adopted.

Res. 5:

Comprehensive Health Planning. The resolution had to do with the definition of the word "provider" and the designation of districts and councils under this law. It was referred to the Council on Medical Service and the Council on Legislation.

Res. 33:

This resolution asks the AMA to negotiate with Congress and the administration in order that in any prepaid medical care system the pluralistic free enterprise payment for services system be retained.

Res. 17:

This calls for a federal constitutional amendment on abortion. The House re-affirmed its existing policy (see P319, June, 1973, proceedings).

REFERENCE COMMITTEE C

Report C, Bd. of Tr. and Res. 21:

These have to do with funding for medical education and research. This is an information report. Medical educators should study this.

Report D. Bd. of Tr.:

This is on allied health education. This described a proposal for the establishment of a joint council for the accreditation of allied health education. This was adopted. Educators of Allied Health Professionals should study this.

Report R, Bd. of Tr. and Res. 156 (A-73):

This is a progress report on a study of practicing physicians on the governing bodies of the American Board of Medical Specialties and individual specialty Boards. The Trustees report was filed and the Resolution report will be made to the Annual Session of the House of Delegates in 1974.

Report A, Co. on Med. Ed.:

Family medicine and medical schools. This is a progress report which was filed. This should be studied by medical educators and the AMA Committee on Medical Education.

Report B, Co. on Med. Ed.:

Special criteria for programs in the basic medical sciences. The report was adopted. In my view, it is unworkable and probably, in many instances, illegal. The report calls for certain prerogatives of control over the 2-year medical school graduates. Adopted. Medical educators please note.

Report F, Co. on Med. Ed. and Res. 130 (A-73) and 142 (A-73):

Report F was in response to Resolutions 130 and 142 which in effect stated that there was unfair and discriminatory action against practitioners of allergy by "The American Board of Allergy and Immunology, and Conjoint Board of the American Board of Internal Medicine and the American Board of Pediatrics." The report requested that the name be changed to "The Conjoint Board of Medical and Pediatric Allergy and Immunology."

Evidently the internists and the pediatricians agreed that this would be done, but since every American Board is separately incorporated we must wait the action by this board to see whether or not the request is carried out. If it is carried out, those practitioners other than internists, pediatricians and Board Certified allergists would not by inference be the only people qualified to practice allergy. The otorhinolaryngologist should follow up on this. Adopted.

Report of Co. on Med. Ed. and Co. on Med. Serv. on Res. 14 (A-73 Nebr.) & 79 (A-73):

These have to do with "third-party rounds" and "private patients and physicians in a teaching hospital." This report clarified the role of the "third-party rounder" and eliminated such odious references as "business rounds." The House also added this important statement, that " a private practitioner who is also a teaching physician may properly combine both of these roles when dealing with his own private patients." This report should be thoroughly studied by hospital medical staffs in all affiliated hospitals. Adopted.

Res. 8:

Model National Contract for House Staff. The House adopted a substitute resolution calling for the Board of Trustees and others in the AMA to develop guidelines on the Model Contract for use by institutions.

Res. 74 and 75:

These have to do with the application of "due process" in dismissing a resident in training. The House reaffirmed its principle of due process as reported by the Judicial Council in 1971.

Res. 76:

Chiropractic practice. This calls for AMA opposition to the recent action of the U. S. Office of Education that a school of chiropractice is an institution of higher learning. This was adopted.

REFERENCE COMMITTEE D

Report H, Bd. of Tr.:

Hospital administrators as presidents of hospital boards. The report recognized that a governing board has the right to elect an administrator as its president. It is strongly recommended, however, that the duties of the chief executive officer and his responsibilities to both the governing board and the medical staff should be defined in such a way that he has no final authority over decisions by either one. Adopted. This action should be noted by hospital medical staffs.

Report Q, Bd. of Tr.:

Recertification and relicensure. Report Q urged that performance evaluation be used rather than a challenge examination or participation in continuing medical education as an index of physician competence or a requirement for re-

certification or relicensure. In addition, the House asks that the Council on Health Manpower, the Council on Medical Education and the Council on Medical Service study this further before recommendations are formulated. Adopted as amended. This report should be studied in depth by our Policy Committee.

Report U, Bd. of Tr.:
Hospital Emergency Department Services. This is a task force report to study the problems involved in hospital emergency department services. It should be carefully studied by every hospital that has such a department. Adopted.

Report C, Co. on Med. Serv.:
On health care of migrant workers. This report calls for the development of an insurance program following the Medicredit proposal and a much clearer definition of the term "migrant worker." Adopted.

Report H, Co. on Med. Serv.:
Physician Hospital Relations. This is an informational report and it was the feeling of the Council that the Delegates should have more time to study it and make their recommendations at the 1974 Annual Convention. Policy Committee and Delegates should study this in depth.

Res. 42 and 71:
Quality Assurance Program of the American Hospital Association. An amended resolution 42 was adopted which called for the AMA to work with AHA to rewrite the Quality Assurance Program manual.

Res. 48 and 68:
These have to do with an intermediary report which evidently anticipated the publication of the January 9th Federal Register regulations calling for pre-admission testing on elective cases. The House took the position that the AMA should take all steps necessary to prevent regulations mandating hospital pre-admission certification under Public Law 92-603 and that the AMA take legal action if necessary to determine whether or not this is in violation of Section 1801 of Public Law 8997.

REFERENCE COMMITTEE E

Report I, Bd. of Tr.:
Drug Abuse. The Board commended the California Medical Association for its statement "Where We Stand on Drug Abuse," but did not recommend adoption as AMA policy, neither did they endorse the publication "Marijuana, a Current Summary," by SIECOP. The House filed the report.

Report J, Bd. of Tr. and Res. 69:
Gonorrhea control. Both of these reports were filed.

Report X, Bd. of Tr.:
Informed Consent. Summaries of the court decision relating to informed consent will be compiled and made available to the physicians on request. Report X was adopted. Every hospital medical staff should have these.

Report Z, Bd. of Tr.:
National Blood Program. This report calls for the approval of the proposed plan to implement the national blood policy. This report was adopted. AMA, AABB, ARC, and others conferred with HEW to reach this decision.

Report A, Jud. Co.:
Death. The report stated that a statutory definition of death is neither desirable or necessary. The report is adopted.

Res. 52:
This calls for the AMA to adopt the definition of "clinical electroneuromyographic examination." It calls for recognition of this examination as being an integral part of the practice of medicine. A substitute resolution endorsed this general concept and added that such examinations be performed under the direct supervision of a qualified physician and urged that state boards of medical examiners investigate instances where unqualified persons performed and interpreted this type of examination. Board of Medical Examiners please note.

REFERENCE COMMITTEE F

Report A, Co. on L.R. Planning:
A progress report. This is a lengthy report which establishes an Office of Planning and the adoption of seven basic planning missions for the AMA. It was adopted.

Report T, Bd. of Tr.:
The House voted that the Annual Session of the AMA be held in San Francisco and the clinical session in Chicago for 1977.

Res. 32:
This calls for the Trustees to seek methods of keeping the public informed about AMA policies. This was adopted.

Report DD, Bd. of Tr. and Res. 26 & 60:
Medical Liability Commission report. Resolution 26 asks the House not to endorse the HEW Secretary's Commission on Medical Malpractice. The Report DD summarized the development of the commission and outlined the structure of membership, fees and assessments for supporting members. The House adopted the Trustees report with three major recommendations and also Resolution 26. All of these should be carefully read by our own Committee on Medical Professional Liability and make appropriate recommendations to the NMA.

Res. 14:
Executive Vice-President. An executive vice-president will be named in March or April of 1974 to succeed Ernest B. Howard, M.D., who will retire in about a year. Anyone who has a nominee should get in touch with the Board of Trustees.

Report AA, Bd. of Tr.; Report BB, Bd. of Tr.; and Res. 16, 34, 64 and 67:
All of these delve into the economic stabilization program and Phase 4. Reports AA and BB were adopted as well as a substitute Resolution 16 which asks the AMA to continue to seek relief for physicians from the discriminatory and unfair regulations under the economic stabilization program. This was adopted. Since that time the AMA has filed suit asking that these regulations be set aside.

REFERENCE COMMITTEE G

Report K, Bd. of Tr.:

On sexual behavior between consenting adults. It calls for support of the position of the American Law Institute which was endorsed by the AMA Council on Mental Health. The institute report states that private sexual conduct between consenting adults is a concern of the individuals and should not be subject to criminal penalties. The report was filed and the Council on Mental Health was instructed to continue the study.

Report L, Bd. of Tr.:

Human sexuality. This report was adopted.

Report F, Co. on Med. Serv.:

Use of the title "family physician" or "family doctor." The House of Delegates believes that the AMA should not be restrictive in the definition of these terms.

Report G, Co. on Med. Serv.:

Health Care of the American Indian. This is an extensive review of the history and present problems of the federal program in health care of the American Indian. It was adopted and referred to the Board of Trustees for implementation. Anyone interested should read this report.

Report L, Co. on Med. Serv.:

Financing Medical Education. This was adopted and should be read by those interested in the subject. Medical schools please note.

REFERENCE COMMITTEE H

Res. 30:

Chronic alcoholism. The House adopted this resolution which has as its purpose a review by hospital's admission policies governing admission of people suffering from alcoholism. Insurance companies are urged to remove unrealistic limitations on the extended coverage for the treatment of alcoholism. This was adopted.

MISCELLANEOUS ITEMS

The Benjamin Rush BiCentennial Award for Citizenship and Public Service was given to the Honorable Otis R. Bowen, M.D., Governor of Indiana.

The Distinguished Service Award was awarded to William F. House, M.D., of Los Angeles, who will receive it at the Annual Meeting in 1974.

The citation of a Layman for Distinguished Service was Nathan J. Start of Kansas City, Missouri, Vice President of Hall Mark Cards.

A special citation was given to Irvin E. Hendryson, M.D., for leadership in emergency medical care.

Respectfully submitted,

John R. Schenken, M.D.
Delegate to A.M.A.

REPORT OF BOARD OF DIRECTORS

George B. Salter, M.D., Norfolk, Chairman; Charles F. Ashby, M.D., Geneva; Dwight W. Burney, Jr., M.D., Omaha; Carl L. Frank, M.D., Scottsbluff; Russell L. Gorthey, M.D., Lincoln.

FINANCIAL STATUS

In the past, the Board at the Annual Session has reported on the financial status of the Association for the previous six months of expenditures. Therefore, this report will cover finances from July 1, 1973, through December 31, 1973.

For the second consecutive year, the Association has been able to realize an increase in surplus funds over 1972. Our surplus at the end of 1973 was in the amount of $11,385. We again expect an income surplus over expenditures for 1974. For the year 1974, the Board has approved a budget of $147,499, which represents an increase of 5.5% over 1973. Thus our budget in general is reflecting only the increased costs of doing business from year to year. This budget is anticipated to meet our expenditures in 1974, assuming that no unexpected expenditures will be encountered.

INVESTMENTS

The investment program of the Association continues in a progressive manner, and as of December 31, 1973, our investments amounted to $87,713.56. The portfolio is composed of treasury notes, municipal and corporate bonds and common stocks. The Board feels that our program is on a sound and equitable basis.

JOURNAL

As you have probably noted over the past several years, the Journal has physically diminished in size. The reduction of the total page content in the Journal is directly related to a continued decline in advertising income, coupled with increased costs of production.

Over the past several years, the Board has also noted increased discussion and amalgamation of individual state journals into regional publications. The latest example is California Medicine which recently combined with Washington and Oregon as the Northwest Medical Journal. The subject of a regional journal has been discussed by the North Central Medical Conference on several occasions. The Boarod wishes the House to be aware of this situation and would seek approval of the House to continue to monitor the subject of a regional journal. If at such time there appears to be strong rationale for a regional journal, the Board will bring the issue before the House of Delegates for discussion and appropriate action. The Nebraska Medical Journal continues to carry a very high rating for its quality of content, and the Board wishes to assure that a quality publication continues to be available for the membership. The Board would welcome any comments the House may have on this subject.

This is my concluding term on the Board of Directors, and as Chairman I wish to express my appreciation to the members of the Association for the opportunity of serving on the Board. It has been a most pleasant task, and I have enjoyed the opportunity of making this contribution to organized medicine.

This concludes the report of the Board of Directors and we sincerely hope that our reports are meaningful and of value to the membership. We are always open to suggestions and comments from the membership.

Respectfully submitted,

George B. Salter, M.D.,
Chairman

REPORT OF THE EXECUTIVE SECRETARY LEGISLATION

This is a final report on bills of interest which were considered by the 1974 Nebraska Legislature.

Bill No., the title and the disposition:

LB 302 — Creates a comprehensive community mental health program. (Passed by the Legislature).

LB 642 — Provided for chiropractic services under workmen's compensation. (Indefinitely postponed on General File).

LB 712 — Adds psychology services covered by health insurance policies. (Passed by Legislature).

LB 727 — Provided for an HMO enabling act. (Indefinitely postponed on General File).

LB 816 — Provided for licensing of medical laboratory personnel. (Indefinitely postponed).

LB 869 — Provided for tax on services not now covered. (Indefinitely postponed).

LB 908 — Reporting of persons with impaired driving ability. (Indefinitely postponed).

LB 963 — Revision of the Medical Practice Act. (Indefinitely postponed on General File).

LB 1005 — Establishing a state-wide residency training program. (Indefinitely postponed on General File).

LB 1051 — Certification for emergency ambulance attendants. (Indefinitely postponed on General File).

LB 131 — Establishes a committee to recommend unified legislation in the fields of medical technology and radiological technology. (Passed by the Legislature).

ANNUAL AND FALL SESSION MEETING SITES AND DATES

In keeping with the needs of the Association to make compatible reservations for future meetings of the Nebraska Medical Association, I respectfully ask the House to indicate meeting sites of Annual Sessions for 1976, 1977, 1978 and 1979. The N.M.A. is scheduled for Lincoln in 1975.

Likewise, we need direction from the House regarding Fall Sessions. We are currently scheduled for Lincoln in 1974, on October 4th and 5th.

In an attempt not to conflict with Cornhusker football, we list herewith recommended dates in October for the football seasons of:

1975—October 2-4—Home game (Miami of Florida)

1976—October 1-2—Home game (Miami)
October 8-9—Away game (Colorado)

1977—September 30-October 1—Home game (Indiana)
October 7-8—Away game (Kansas State)

1978—September 29-30—Away game (Indiana)
October 6-7—Away game (Iowa)

Respectfully submitted,
Kenneth Neff,
Executive Secretary

REPORT OF THE AD-HOC COMMITTEE ON PSRO

James H. Dunlap, M.D., Chairman, Norfolk; John H. Bancroft, M.D., Kearney; Allan C. Landers, M.D., Scottsbluff; Donald J. Pavelka, M.D., Omaha; Houtz G. Steenburg, M.D., Aurora; Frank P. Stone, M.D., Lincoln; Carlyle E. Wilson, Jr., M.D., Omaha.

P.L. 92-603 was enacted by Congress in the Fall of 1972. Prior to its enactment, the American Medical Association vigorously opposed such action. Section 249F of this law was a sixteen-page amendment to the original act which was, in fact, a 165-page compilation of amendments to the Social Security Act. This amendment was never debated on the floor of Congress, and, as such, passed unnoticed by most members of Congress. Your Ad-Hoc Committee was formed at the 1973 Annual Session of this House of Delegates and was charged with the "study of PSRO legislation and the NMA's future role, if any, in PSRO, and . . ." We have interpreted this charge to mean that we, as an Ad-Hoc Committee, should continue a general surveillance of PSRO with its multiple problems, and offer to you a contingency plan of action.

The current national status of PSRO implementation is one of chaos and confusion. This seems equally true both on the part of government and organized medicine and on the part of individual physicians. Currently, the government has announced the recognition of PSRO areas. Nebraska has been designated as a single area for planning purposes. The Federal legislation, as it currently stands, demands the implementation of operative machinery in each of these designated areas by January 1, 1976. Currently, bills have been introduced both at the U.S. House of Representatives and the U.S. Senate for repeal of the "PSRO law." Whether or not these legislative proposals will be successful is speculative. In the event they are not successful, the AMA is committed to a course of attempted modification of the current law to render it less odious.

As with all of medicine across the United States, your Ad-Hoc Committee finds itself in a dilemma. This dilemma is created as a result of multiple uncertainties. These uncertainties, of course, hinge upon such action as Congress, the courts, and the stand organized medicine itself will ultimately take. **We are in favor of the repeal of PSRO as recorded by our House of Delegates in its Fall, 1973, session.** Should such action fail, we are in favor of Congressional modification of the law in such fashion as to best insure the continuation of delivery of quality medicine and to preserve individual rights and freedoms.

The study of PSRO in general has caused your Ad-Hoc Committee collectively and individually considerable soul searching. We have travelled extensively in our studies of various types of organizations, both proposed and functioning, which have been formed across the nation to solve the problems to which PSRO was purported to address. All of the institutions which we visited were formed prior to PSRO's conception in Congress. These studies have led us to believe that our best course of action in Nebraska would be the formation of a "Nebraska Medical Care Foundation, Inc." It is our belief that such a Foundation as outlined in the enclosed, proposed Articles of Incorporation would leave us in an advantageous position. Such a Foundation should be a freestanding

corporation, not subject to formal ties with the Nebraska Medical Association, but should, none-the-less, be governed by the officials of the NMA. Its purposes shall basically be those of improvement of the quality, distribution, and access to good medical care. We envision the staffing of such a formation with much the same personnel as will be simultaneously employed by the NMA. The initial financing of this Foundation we anticipate by private or individual subscription. At the present time, the activities of our newly formed NMA health planning committee might be an appropriate area for Foundation activity. Additionally, coordination and cooperation with our Peer Review Committee on a fee-for-service basis in fee adjudication matters might be considered. In any event the Nebraska Medical Care Foundation, Inc., if created, may well represent the Nebraska Medical Association "friend" in dealing with PSRO should such action ultimately become necessary. We can then envision a situation arising when Congress ultimately fails to repeal or substantially modify the existing law. In this event, PSRO will become a reality in Nebraska. Should such a time arise, your committee envisions the likelihood of this PSRO unit interacting with the Nebraska Medical Care Foundation, Inc. by subcontracting its obligatory function to this Foundation.

Your Ad-Hoc Committee feels that as a committee we cannot recommend to you a course of action which would lead to the assumption of an impossible, inflexible posture by the NMA. We believe that the creation of a Foundation as outlined both in this report and in the proposed Articles of Incorporation will leave the House of Delegates multiple options for future conduct and policy decisions, which options we feel must be left open because of the uncertainties of action on the part of the Federal government, the American people, and the American Medical Association.

Our charge of surveillance and contingency planning of PSRO and the NMA's future role, if any, in dealing with this matter continues to seem appropriate. If this course is to be followed, your committee wishes to reassure you that the committee will commit itself to no other course of action than that which is outlined in this report, without the express approval of the NMA House of Delegates.

Respectfully submitted,
James H. Dunlap, M.D., Chairman

ARTICLES OF INCORPORATION OF NEBRASKA MEDICAL CARE FOUNDATION, INC.

I.

The name of the corporation shall be "Nebraska Medical Care Foundation, Inc." It is herein referred to as the "Foundation."

II.

The duration of the Foundation shall be perpetual.

III.

1. The Foundation is a nonprofit corporation organized under the Nebraska Nonprofit Corporation Act for the following charitable, scientific and educational purposes:

To promote the general welfare and health of the people of the State of Nebraska by encouraging the distribution of medical services by its members to the people of Nebraska at a cost reasonable to both patient and physician; to preserve unto its members, the medical profession at large, and the public, freedom of choice of both physician and patient; to guard and preserve the physician-patient relationship and its innumerable benefits; to work in conjunction with the Nebraska Medical Association, a non-profit corporation, county medical societies throughout the State of Nebraska, and other organizations in developing and promoting the art and science of medicine, the protection of the public health, and improvement of the medical profession; to study objectively the strengths and weaknesses of the medical care delivery system in the State of Nebraska and work toward upgrading any deficiencies which may be found therein; to promote, develop and foster the availability of high quality health care, either alone, or in conjunction with individuals, physicians, medical societies and other professional organizations; to make available the organization's reviewing and consultative services to any organization desiring to contract for them; and to engage in any other lawful activities authorized by statute or bylaws of said Foundation.

2. No part of the net earnings of the Foundation shall inure to the benefit of any member, director, officer of the Foundation or any private individual (except that reasonable compensation may be paid for services rendered to or for the Foundation affecting one or more of its purposes), and no member, director, officer of the Foundation or any private individual shall be entitled to share in the distribution of any of the corporate assets on dissolution of the Foundation. No substantial part of the activities of the Foundation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Foundation shall not participate in, or intervene in (including the publication or distribution of statements) any political campaign on behalf of any candidate for public office.

3. Notwithstanding any other provision of these Articles of Incorporation, the Foundation shall not conduct or carry on any activities which are not permitted to be conducted or carried on by an organization which is exempt from taxation under Section 501 of the Internal Revenue Code or by any organization contributions to which are deductible under Section 170 of such Code and the Regulations thereto as they now exist or as they may be hereafter amended.

4. Upon dissolution of the Foundation or the winding up of its affairs, the assets of the Foundation shall be distributed exclusively to charitable, religious, scientific, literary or educational organizations which would then qualify under the provisions of Section 501 of the Internal Revenue Code and its Regulations as they now exist or as they may be hereafter amended.

IV.

The membership of this Foundation shall consist of the members of the Board of Directors. The administrative, business and prudential affairs of the Foundation shall be directed by a Board of Directors which shall consist of twelve (12) individuals who are the Board of Councilors of the Nebraska Medical Association, having its principal office in Lincoln, Nebraska. Every person upon becoming a member of the Board of Councilors of said Nebraska Medical Association shall be entitled to become, and shall be without other or any action or proceeding, a member of the Board of Directors of this Foundation. Whenever any member of the Board of Directors of this Foundation ceases for any reason whatsoever to be a member of the Board of Councilors of the Nebraska Medical Association, his membership on the Board of Directors of this Foundation shall immediately and automatically cease and terminate. Acceptance of membership on the Board of Directors shall be deemed to be acceptance of and intention to be bound by the Articles of Incorporation and Bylaws of the Foundation.

V.

The Board of Directors shall elect officers of the Foundation, consisting of a president, one or more vice-presidents, secretary, treasurer, and such other officers as the Board determines to be necessary to accomplish the purpose of the Foundation. The offices of secretary and treasurer may be held by the same person. The officers need not be members of the Board of Directors. The Executive Secretary of the Nebraska Medical Association shall be the Executive Director of the Foundation and shall be an **ex-officio** member of the Board of Directors, without voting rights as a Board member.

VI.

The initial Board of Directors shall consist of the following persons:

Name Address

VII.

The address of the initial registered office is 1902 First National Bank Building, Lincoln, Nebraska, and the name of its registered agent at that office is Kenneth Neff.

VIII.

The incorporators are:

Name Address

Executed at_____, Nebraska this _____day of_____, 1974.

_____
Incorporator

_____
Incorporator

_____
Incorporator

_____
Incorporator

REPORT OF THE HEALTH PLANNING COMMITTEE

Richard A. Cottingham, M.D., Chairman, McCook; James G. Carlson, M.D., Verdigre; C. J. Cornelius, Jr., M.D., Sidney; F. H. Hathaway, M.D., Lincoln; Robert G. Osborne, M.D., Lincoln; James E. Ramsay, M.D., Atkinson; C. Lee Retelsdorf, M.D., Omaha; Stanley M. Truhlsen, M.D., Omaha.

A survey has been developed by the Nebraska Medical Association Health Planning Committee. It will be used on a trial basis at this session of the House of Delegates for purposes of measuring its effectiveness and applicability.

An oral report will be made at the session to explain the usage of the survey form in more detail and to amplify on the current and future activities of the committee.

Respectfully submitted,
Richard A. Cottingham, M.D.,
Chairman

REPORT OF THE POLICY COMMITTEE

John D. Coe, M.D., Chairman, Omaha; James H. Dunlap, M.D., Norfolk; Frank P. Stone, M.D., Lincoln; Roger D. Mason, M.D., McCook; J. Whitney Kelly, M.D., Omaha.

Recognizing that annual reports of the committees of the Association are presented to the House of Delegates at its Fall Session, your Policy Committee decided that a progress report would be apropos at this time as there are several action and informational items that should be brought to the attention of the Association at this time.

I. The current situation at the University of Nebraska Health Service in Lincoln was brought to the attention of the committee. After considerable research, discussion, and consideration of all aspects of the matter, the committee issued a letter of support for Doctor S. I. Fuenning based upon the need for high quality medical care within the institution. There must be confidentiality of medical records and the high quality of health care that has been provided must be maintained. The committee's decision was further solidified by considering such items as the "Recommended Standards and Practices for a College Health Program" as formulated by the American College Health Association in its Revised 1969 Edition.

The letter sent to the Chairman of the Board of Regents by the Policy Committee on April 11, 1974, read as follows:

April 11, 1974

The Honorable Regent Kermit Hansen
Chairman, University of Nebraska
Board of Regents
P. O. Box 3408
Omaha, Nebraska

Dear Regent Hansen:

The current controversy over the operation of the University of Nebraska Health Center has come to the attention of the Nebraska Medical Association and was discussed in some detail by the Policy Committee at their meeting March 28, 1974.

The Nebraska Medical Association over the years has noted with pride the excellence of the University of Nebraska Health Center, and has been aware that its Director, S. I. Fuenning, M.D., has become a nationwide authority over the past twenty-

five years in the development and operation of such services.

We have also been pleased that he has seen fit to develop these medical services in a proper and ethical manner, which protects not only the physical and mental well-being but the confidentiality of the students receiving these services.

He should be commended for his excellence, and great care should be exercised that organizational realignments of the University do not destroy this present medical system.

The Policy Committee supports Doctor Fuenning and will suggest that the resolutions offered by the physician members of the University Health Center be considered favorably at the Annual Meeting of the Nebraska Medical Association in Omaha on April 29th.

Sincerely yours,
John D. Coe, M.D.
President

The Policy Committee here recommends to the House of Delegates that this action be endorsed and that the concepts being expressed be ratified.

II. The Mental Health and Retardation Committee of the NMA prepared and submitted to the Policy Committee for consideration a letter which addressed itself to Section 1945 of Senate Bill 2513. This bill is one of the national health insurance proposals and the section being questioned is that relating to the mental health care provisions. This section of the bill in essence would limit care to certain individuals for illnesses by reason of the type of illness they had. The letter was sent to Senator Curtis with copies going to the Senate Finance Committee, Doctor Howard of the AMA, and the District Branch of the American Psychiatric Association. The Policy Committee accepted the letter and recommended that it be sent as proposed.

III. As in past years, the NMA is exchanging a representative with the Nebraska Dental Association in an effort to foster and maintain communication between the two organizations.

Doctor J. Whitney Kelley was selected by the Policy Committee as the NMA representative to the forthcoming Annual Meeting of the Nebraska Dental Association.

The Dental Association's representative to the NAM Annual Session will be Doctor A. G. Rimmerman of Omaha, Nebraska.

IV. The Policy Committee considered endorsement of a Quality of Life Conference being planned by the Woman's Auxiliary to the Omaha Medical Society in conjunction with the University of Nebraska Medical Center. The Policy Committee endorsed the value of such a conference and lended support of the NMA.

The conference was tentatively scheduled for a date in conjunction with this Annual Session, but because of timing and conflicting scheduling it was decided it would be better rescheduled on a date in the fall. It is anticipated information will be forwarded to County Medical Societies in future months.

V. The committee considered a letter from Mrs. Kenneth T. McGinnis, President-elect of the Woman's Auxiliary to the Nebraska Medical Association which solicited comments regarding the Auxiliary's interest in development of an organization entitled, "Friends of Nebraska Health Museums." The Auxiliary is considering the launching of a fund-raising campaign to develop the Health Museum as has been proposed for several years. The committee commended the Auxiliary's interest and activity in this regard and asked that it be kept informed regarding progress.

VI. The committee considered and endorsed a letter by the President of the NMA to all State Medical Associations promoting consideration of the concept of repeal of current PSRO legislation and calling attention to the materials prepared and distributed by Doctor Schenken, NMA Delegate to the AMA.

VII. The committee considered and endorsed the selection of Doctor Donald Matthews as Program Coordinator of the Nebraska Regional Medical Program. His predecessor Doctor Deane Marcy had resigned as of April 1st. Doctor Matthews was subsequently hired by the Regional Advisory Group and is serving on a percentage of time basis during the phase-out period of the Regional Medical Program.

VIII. Representatives of the NMA met with personnel in the State Fuel Allocation Office regarding the necessity of physicians in all areas of the state to have access to a sufficient fuel supply. The Fuel Allocation Office has made available a list of available stations or fuel sources and a copy of the listing may be obtained from the NMA Headquarters Office.

Your Policy Committee stands ready to assume the responsibilities which might be assigned to it by the House of Delegates at this Session. We trust this report will serve as an indication of the efforts exercised by the committee in behalf of the members of the NMA.

Respectfully submitted,
John D. Coe, M.D., Chairman

REPORT OF THE PUBLIC RELATIONS COMMITTEE

William T. Griffin, M.D., Chairman, Lincoln; James S. Carson, M.D., McCook; William S. Carter, M.D., Omaha; Roger D. Mason, M.D., McCook; Donald E. Matthews, M.D., Lincoln; G. P. McArdle, M.D., Omaha; Robert J. Henderson, Omaha.

This report is being presented to the House of Delegates at this time because of the recent completion of the film entitled "But For the Grace." The committee's Annual Report will be presented at the Fall Session carrying the detailed analysis of activity areas such as news releases, public service materials, recorded announcements, etc.

The film is the third such activity of the committee. The first project was the production of a video taped film on breast cancer designed to provide information on this subject to the layman. The second video taped program focused on the prevention of athletic injuries and was given considerable showing by television stations across the state.

"But For the Grace" is the NMA's new documentary film featuring a young traffic accident victim who experienced trauma and is still experi-

encing the long rehabilitation effort which can follow a traffic accident. The former Nebraska high school athlete discusses the difficulties and changes in his life resulting from an automobile accident six years earlier. The film focuses on the fact that a healthy attitude is crucial to safe driving.

Several NMA members appear in the film making statements on various traffic safety problems.

The film was made possible partially by a grant from the Nebraska State Department of Motor Vehicles. An award has been presented the NMA by the Nebraska Highway Safety Program for our efforts in making the film. It was produced by The Thompson Company which serves as NMA public relations counsel.

A publicity campaign is planned to promote use of the film in Nebraska schools and by local youth groups. The assistance of NMA members in this regard will be appreciated. Bookings for showing may be made by contacting the NMA Headquarters Office. Several agencies are purchasing copies of the film, and it is released for television use.

Several press conferences are being planned during the Annual Session to cover actions taken by the House of Delegates and allow discussion with our officers and guest speakers.

The Public Relations Committee stands ready to assume any directives given to it by the House of Delegates.

Respectfully submitted,
William T. Griffin, M.D.,
Chairman

PROGRESS REPORT OF NEBRASKA REGIONAL MEDICAL PROGRAM

In late 1972, considerable effort of time and resources was devoted to the development of a triennial grant application to fund 12 new and 3 ongoing projects in this region. Activities of the Regional Advisory Group, its committees, and program staff were reaching a peak in completing the application. Then in early 1973, the abolishment of the Regional Medical Programs was rumored with confirmation coming on February 1, 1973. The administration slated termination of the program for June 30, 1973. Through the foresight of several individuals, the Regional Advisory Group met on February 7, 1973, to approve the triennial grant application for submission to the Division of Regional Medical Programs.

Immediately following this action, a plan was developed for phasing out the program. During the spring of 1973, four operational projects were discontinued five months prematurely and three others were severely restricted in their activities. Plans for full project implementation for some of the approved mini-grants and feasibility studies were terminated. Of the 24 professional and secretarial staff working for the program, 14 were terminated in April of 1973. Two others later departed for new positions during the summer. Work was directed toward closing out the program as final reports were being verified, financial status was being audited, and files were being sorted, cataloged and made ready for storage.

April and May of 1973 brought prevalent rumors that the Congress would not permit Regional Medical Programs and 11 other health programs to die on June 30, 1973. On June 18, 1973, extension legislation for Regional Medical Programs was signed by President Nixon. However, budgetary constraints continued to tightly restrict the program's activities, some services were eliminated and no new projects could begin. Uncertainties continued until late summer and early fall.

Nationally, a law suit was filed in Federal District Court to release the 120 million of money impounded from the Regional Medical Programs to allow them to continue operation beyond the new cut-off date of February 14, 1974. On October 1, 1973, the Nebraska Regional Medical Program received a small grant award to allow continuation of the program, and begin four new projects which were scaled down versions of those approved by the Regional Advisory Group in the triennial application. The Division of Regional Medical Programs followed this with two required applications to provide funds from January 1, 1974, to June 30, 1974, plus a compilation of the program's activities since September 1, 1972.

As the workload began increasing in the fall, new financial and management systems were initiated and efficiency of the program was improved. Other aspects of the program were upgraded: the Learning Resource Center increased its library of multimedia programs for the first time since mid-1972 by adding 130 new presentations and 50 duplicate copies of highly demanded materials. The Drug Information Service was able to resume its publications of the **Drug Update** and provide more comprehensive service.

By the end of 1973, five operational projects had completed activities, seven mini-grants were concluded, two ongoing and ten new projects were operational and six more were ready to be implemented. Requests for staff asistance through the Drug Information Service and Learning Resource Center had increased. The Nebraska Regional Medical Program Staff had been instrumental in the development of an Emergency Medical Service grant application to the Robert Woods Johnson Foundation and numerous other EMS activities throughout the State.

A decision was reached by the Nebraska Regional Medical Program's planning committee to seek proposals for new activities based on the Nebraska Regional Medical Program's approved goals and objectives and consistent with the 1971 Division of Regional Medical Program's Mission Statement and priority areas issued in late 1973. A streamlined review cycle was designed and requests for new projects were communicated to the region. The response was overwhelming with 62 project proposals being submitted to the Nebraska Regional Medical Program. Through the review process, this number was narrowed to 22 projects which will be submitted to Washington on May 1, 1974. The starting date for these new projects, if sufficient funds are received, will be July 1, 1974, and will run until June 30, 1975. An additional application will be submitted to Washington on July 1, 1974, with the starting date of September 1, 1974.

In December, 1973, the first legislation (HR 12053) was introduced in Congress to revise the Public Health Service Act. This legislation, as introduced by Congressman Hastings, Rogers, and

Roy, proposed to combine the functions of RMP, CHP, and Hill-Burton. Since that time, several other legislative bills have been introduced with a variety of approaches. The latest report from Washington would indicate that the hearings and final outcome of this legislation will not be reached until late 1974 or early 1975.

On April 1, 1974, Deane S. Marcy, M.D., who has served as Coordinator for the Nebraska Regional Medical Program since July of 1971, retired. He was replaced by Donald Matthews, M.D., who, as a consultant with the Nebraska State Department of Health, has been actively involved with various Nebraska Regional Medical Program committees. Doctor Matthews also serves as Director of Emergency Medical Services, Lincoln General Hospital, in Lincoln.

Respectfully submitted,
Darrell D. Buettow,
Deputy Coordinator

REPORT OF INSURANCE AND PREPAYMENT MEDICAL CARE COMMITTEE

Arthur L. Smith, M.D., Chairman, Lincoln; Harold Dahlheim, M.D., Norfolk; Russell J. McIntire, M.D., Hastings; Paul M. Scott, M.D., Auburn; Stanley M. Truhlsen, M.D., Omaha; Hiram R. Walker, M.D., Kearney.

Your committee has met often and spent many hours on many occasions during the past year reviewing the current Nebraska Medical Association endorsed insurance program.

Frequent and major consideration has been given to the professional liability program with two to four times monthly discussion of possible cases and frequent monitoring of the whole professional liability program. There is an ever increasing number of cases in the state and continued participation by the Nebraska Medical Association and St. Paul Insurance Company is an absolute necessity.

The current group life insurance program with Woodmen Accident and Life Company ($25,000 current maximum) has been reviewed and several companies and agencies have been invited to submit and have submitted group life insurance programs. It is evident that a group life policy with much higher limits than currently available is advisable and necessary, and your committee has accepted the life insurance package offered by Western Life Insurance Company, a subsidiary of the St. Paul Insurance Company. A policy will be available in units of $25,000 up to a maximum of $250,000 of group term coverage. Members currently insured under the Woodmen program would automatically be accepted by Western Life for the present amount of life insurance in force. Additional life insurance would of course require a health questionnaire acceptable to the company, and in the higher life insurance amounts would require physical examination.

Your committee has considered disability income insurance and business overhead expense insurance, but we do not believe that we have yet reached proper and necessary maximum benefits required by present inflationary trends. Additional negotiation will continue and information will be presented to the House of Delegates at a later date.

Respectfully submitted,
Arthur L. Smith, M.D.,
Chairman

REPORT OF THE MEDICAL EDUCATION COMMITTEE

John W. Smith, M.D., Chairman, Omaha; James E. Bridges, M.D., Fremont; Wendell L. Fairbanks, M.D., Auburn; James S. Long, M.D., Alma; R. C. Rosenlof, M.D., Kearney; Robert J. Stein, M.D., Lincoln; Joseph M. Holthaus, M.D., Omaha; Robert B. Kugel, M.D., Omaha; Mr. Timothy Wahl, Omaha.

The Medical Education Committee met recently and discussed the three basic areas of medical education, namely undergraduate, graduate and continuing education. The committee here presents its recommendation in each of these areas.

(1) The Nebraska Medical Association supports the concept of voluntary continuing education for its members. Those activities in continuing education which will qualify the member for the A.M.A. Physician's Recognition Award or for the requirements of his Specialty Society are suggested as initial guidelines. Your Education Committee would like to work on details for further implementation of such a program and a recognition certificate.

As of January, 1974, five state medical associations have such a voluntary requirement and ten state associations have a compulsory continuing education requirement for membership. Three states have new relicensure laws requiring continuing education for physicians.

(2) It has been clearly demonstrated that physicians who take their graduate training in Nebraska are likely to remain in the state to practice. Such graduate education is expensive. At present these programs are funded for the most part by additions to the daily bed charge of the hospitals. In the future, with increasing concern by third parties about costs, education costs may not be reimbursed. It is essential that the State Association explore with the universities the possible alternate sources of financing.

(3) RESOLUTION

WHEREAS there are still areas in Nebraska without adequate physician coverage, and

WHEREAS there are in a number of areas need for specialists in some fields of practice of medicine, and

WHEREAS the University of Nebraska College of Medicine and Creighton University School of Medicine have established goals to attempt to alleviate these problems and to set up cooperative patterns of health care between areas in Nebraska and the Universities;

BE IT RESOLVED that the Nebraska Medical Association support these objectives and goals of the two Universities, and be it further

RESOLVED that the Nebraska Medical Association and the Universities increase their communication with each other, and be it further

RESOLVED that the Nebraska Medical Association work with the Universities in assisting them in gaining adequate financial support to strengthen the schools.

The committee recognizes there is much to be done by the Nebraska Medical Association in the area of medical education and assumes the responsibility of representing the Association in this very important area of concern. The committee

stands ready to assume also, any additional items given it by the House of Delegates at this Session.

Respectfully submitted,

John M. Smith, M.D., Chairman

REPORT OF RELATIVE VALUE STUDY COMMITTEE

Orin R. Hayes, M.D., Chairman, Lincoln; Patrick C. Gillespie, M.D., Beatrice; Bernard L. Kratochvil, M.D., Omaha; Lyle H. Nelson, M.D., Crete; Donald F. Purvis, M.D., Lincoln; Carlyle E. Wilson, Jr., M.D., Omaha.

The Committee has met on multiple occasions for consideration of the preparation of an up-dated Nebraska Relative Value Study. Many problems have been encountered that continue to delay the final draft of a study. It is the Committee's feeling that a veritable impasse has been achieved and some of the reasons are outlined for consideration.

Item 1: The assignment to this Committee by the House of Delegates of the Nebraska Medical Association was to revise the 1965 Relative Value Study in order to up-date the study to include the many newer procedures that have been developed since the publication and to assign relative values to the procedures. It was further recommended that the Committee attempt to relate all procedures of all specialties in such a manner to permit a single conversion fee to be applied to the procedures as performed by any physician. To this end, the Committee solicited fees from all specialty organizations for procedures performed by their members under the five-digit codification of the Current Procedural Terminology as up-dated and printed by the American Medical Association in October of 1973. All of the schedules were finally received by March 14, 1974, and at that time the code numbers and fees for the various specialties were assembled and compared. At that time, it was obvious that there was a considerable variation in fees for the same code number and a single relative value could not be assigned in a considerable number of procedures due to the variation in the fees of the specialty societies. Only the Medicine section was considered and it was obvious that the same thing will occur when applied to the section of Surgery and surgical sub-specialties.

Item 2: The Committee requests direction on the method of assigning relative values for procedures when there is discrepancy of more than one specialty society. Should this be an arbitrary decision on the part of the Committee members?

Item 3: The Committee requests that the House of Delegates state whether this Committee is responsible for producing a Relative Value Study or whether they are responsible for producing a uniform fee schedule for the physicians of the State of Nebraska.

Item 4: The Committee feels that each physician should be entitled to charge whatever fee he deems reasonable for his services and that no structured and adopted schedule should subvert this aim. The Committee feels that the schedule will permit symmetry within an individual physician's fee schedule but the schedule is in no way inferred or intended to raise or lower fees on a statewide basis. It is therefore the responsibility of the physician to establish his own conversion factor to be applied to the relative values as outlined in the anticipated study.

Item 5: At the present time some of these problems are of such magnitude that a uniform relative value is impossible. We therefore feel that a new approach will have to be made if the fees as submitted are to be used for constructing and up-dating a new relative value study.

Respectfully submitted,

Orin R. Hayes, M.D., Chairman

Report of Board of Councilors

First Session

The first session of the Board of Councilors was held April 28, 1974, at the Omaha Hilton Hotel, Omaha, Nebraska. The meeting was called to order by the Chairman, Dr. Houtz Steenburg.

Councilors present were Drs. Louis Gogela, H. C. Stewart, Robert Benthack, Robert Sorensen, Houtz Steenburg, Lyle Nelson, Hiram Walker, Fred Rutt, and Bruce Claussen. Dr. Stanley Truhlsen was also present to represent the First District in the place of Dr. Thomas Gurnett.

The minutes of the 1973 Fall Session were approved as printed in the December, 1973, issue of the Nebraska Medical Journal.

Dr. Steenburg called for election of one member of the Board of Directors, replacing Dr. George Salter who is not eligible for reelection. This was deferred until the second session.

The Board of Councilors reelected Dr. W. O. Brown to the Medicolegal Advice Committee, and Dr. C. B. Dorwart to the Council on Professional Ethics.

The requests for Life Membership were received and approved by the Board of Councilors.

The Councilors approved the recognition of the Perkins-Chase County Medical Society as a newly organized county society.

The committee reports in the Handbook were reviewed and accepted by the Board of Councilors.

The resolutions were reviewed with special attention to Resolution #4. The Board of Councilors felt that the Ad-Hoc Committee on PSRO should be retained to continue the study of the problem, and they felt that the intent of this resolution was to attempt to divorce ourselves from federal intervention.

There was considerable discussion regarding Resolution #7, concerning the UNL Health Service Program, and interested individuals were requested to appear before the Reference Committee.

An oral report of the Ad-Hoc Committee on Membership was presented by Dr. Harry McFadden, Chairman.

There being no further business, the meeting was recessed until Monday morning.

Report of Board of Councilors

Second Session

The second session of the Board of Councilors was held April 29, 1974. This meeting was called to order by the Chairman, Dr. Steenburg.

The following Councilors were present: Drs. Thomas Gurnett, Louis Gogela, H. C. Stewart, Robert Benthack, Robert Sorensen, Lyle Nelson, Hiram Walker, and Bruce Claussen.

Dr. Benthack informed the Board of Councilors that he wished to resign as Councilor of the Fourth District. This was accepted by the Board.

Dr. Steenburg called for election of the one member of the Board of Directors to replace Dr. Salter, and the motion was made that Dr. Benthack be elected as a member of the Board of Directors. This was approved.

Dr. Steenburg asked for approval of the minutes of the first session, and these were approved as printed.

There was discussion as to the selection of an acting Councilor for the Fourth District. However, it was decided to defer this until the Fall Session, and if a replacement was needed prior to that time, this could be handled by a conference call of the Board of Councilors.

There being no further business, the meeting was adjourned.

Report of House of Delegates

First Session

The first session of the House of Delegates was held April 28, 1974, at the Omaha Hilton Hotel, Omaha, Nebraska. The meeting was called to order by the Speaker, Dr. Harry McFadden.

The call for a quorum showed 63 delegates were present, and the House was declared in session.

The Chair recognized Dr. Wm. Griffin, who introduced the new film, "But For the Grace," which was shown to the House at this time.

Dr. John D. Coe, President, then presented a plaque to Dr. Earl Leininger for his many years of service as Delegate to the American Medical Association.

The following oral reports were presented to the House:

Dr. Max Parrott, Portland, Oregon — AMA Board of Trustees

Dr. A. G. Rimmerman — Representative of the Nebraska Dental Association

Dr. Richard Andrews — Assistant Dean, Creighton University School of Medicine

Dr. Robert Sparks — Chancellor, University of Nebraska Medical Center

Dr. Richard Cottingham — Chairman, Health Planning Committee

Dr. Harry McFadden, Chairman of the Ad-Hoc Committee on Membership, presented the following progress report for information of the House:

At the time of Doctor John D. Coe's discussion of membership during the last meeting of the House of Delegates, he indicated that the Nebraska Medical Association dropped the mandatory membership in AMA requirement in 1971 and that since that date membership had dropped from 1,222 to 995. Fortunately, life members are counted in the total for determination of Delegates to the AMA.

As of April 9, 1974 the membership situation has improved as shown below.

MEMBERSHIP BREAKDOWN
(As of April 9, 1974)

*Active	1,231	
Life	118	
Service	1	
Total	1,350	
*State and AMA	1,008	
State Only	223	
Student Membership:		
University	25	(2 AMA)
Creighton	4	
Total	34	(9 AMA)
Associate Membership:		
University	25	(2 AMA)
Creighton	4	
Miscellaneous	7	(3 AMA)
Total	36	(5 AMA)

The Ad-Hoc Committee wishes to compliment our President, Dr. John D. Coe, for his interest in and effective work to improve membership in AMA, NMA and local societies and suggests that our next President, Dr. James H. Dunlap, continue such emphasis on membership.

Specifically the Ad-Hoc Committee recommends: (1) The President of the NMA continue to send a personal letter of welcome, explaining the role of organized medicine, to potential new members on their entrance to practice in the State. (2) President Coe's request that Councilors be provided with a list of physician non-members in their district and that they or their designee contact the non-members as individuals be continued on an annual basis. (3) Individual members of the NMA be encouraged to recruit non-member physicians to the society.

Attention of the delegates is called to the 1974 County Society Membership data provided by Mr. Neff and staff in your delegate Handbook.

The Ad-Hoc Committee recommends that the concept that "Members take a House Officer or medical student to local society meetings" be continued and encouraged. The committee compliments Dr. Whitney Kelley and all others who have encouraged such participation thus far.

For the information of the delegates the Omaha Medical Society recently approved the following statement concerning House Officers.

HOUSE OFFICERS

It was moved, seconded and approved that House Officers pay $15.00 annually for county society dues. Dinners attended by these members will be paid for on an individual basis.

It was also moved, seconded and approved that each medical school be represented on the Executive Board by one (1) member of the County Society.

The Ad-Hoc Committee has begun discussions of ways and means to: (1) Improve participation by House Officers and medical students in AMA, NMA, and local societies. (2) Develop orientation programs for medical students, house officers and new physicians entering the State. (3) Develop packets of informational material for new physicians (this in conjunction with the Public Relations Committee of the NMA).

The Ad-Hoc Committee submits this information as a progress report and anticipate a more detailed report at the Fall Meeting of the House of Delegates.

The Speaker called for approval of the 1973, Fall Session minutes of the House of Delegates, as printed in the December, 1973, issue of the Nebraska Medical Journal, and these were approved as printed.

Reference Committee members were approved and committee assignments were made as follows:

Reference Committee #1
- Audit
- Board of Directors
- Delegate to AMA
- Executive Secretary
- Resolution #2 — Driver Safety Legislation

Reference Committee #2
- Insurance and Prepayment Medical Care
- Relative Value Study
- Resolution #1 — Opposition, "Hold-Harmless" Clause
- Resolution #5 — Nebraska Relative Value Study

Reference Committee #3
- Ad-Hoc Committee on PSRO
- Health Planning Committee
- Resolution #4 — Opposition to PSRO
- Resolution #6 — Repeal of PSRO

Reference Committee #4
- Policy
- Resolution #7 — UNL Health Service Program
- Life Memberships

Reference Committee #5
- Public Relations
- Regional Medical Program
- Medical Education
- Resolution #3 — Emergency Medical Communications

The following Nominating Committee was selected and approved:

1st District — Donald Pavelka, M.D.
2nd District — John McGreer, M.D.
3rd District — Patrick Gillespie, M.D.
4th District — James Carlson, M.D.
5th District — Thomas Erickson, M.D.
6th District — John Hansen, M.D.
7th District — R. Cassel, M.D.
8th District — Floyd Shiffermiller, M.D.
9th District — James Peck, M.D.
10th District — Fred Rutt, M.D.
11th District — R. F. Getty, M.D.
12th District — Allan Landers, M.D.

Dr. McFadden called for resolutions from the floor. Resolution #8 was introduced by Dr. McWhorter, Omaha Medical Society. Opposition to Phase IV Price Controls. This was referred to Reference Committee #2.

Dr. McWhorter asked that Resolution #6 be modified by changing the wording of the second RESOLVED to read as follows:

"RESOLVED, that a suitable resolution be prepared requesting the AMA to work vigorously for repeal of PSRO in order to provide leadership to its component societies; and be it further"

Following announcements, the House was recessed until Monday morning.

Report of House of Delegates

Second Session

The second session of the House of Delegates was held April 29, 1974. The meeting was called to order by the Speaker, Dr. Harry McFadden.

The call for a quorum showed 60 delegates present, and the meeting was declared in session.

Oral reports were presented by the following:

Mrs. J. Whitney Kelley — State Chairman, AMA-ERF

Dr. Robert Kugel — Dean, University of Nebraska College of Medicine

Dr. John P. Gilligan — Chairman, Medicolegal Advice Committee

Dr. Henry Smith — Director, State Department of Health

Dr. John J. Regan, President of the Minnesota State Medical Association, was introduced to the House of Delegates by Dr. Coe for a few brief remarks.

Dr. Colon was granted permission of the floor for the following remarks:

"I have accumulated some observations and comments I'd like to make.

"For the last 2½ years, I have had the unique opportunity of becoming a pseudo politician being involved in Comprehensive Health Planning in the state, and now as a member of the State Board of Health, and also always an interested party, trying to improve the medical outlook, not only for the physicians in the state but the private citizens of our state.

"I have been concerned at this meeting, to some extent as I walk around and look at these delegates here, to notice we do not have the general feeling that we should have if we are to be called organized medicine. I suspect that more than being called organized medicine, we really should be called disorganized medicine when we take into view the lobby structures of other very interested groups such as the chiropractic association and the labor

unions COPE program. I look at us in this room and I see too many of us without that AMPAC slip on our name tag. If this is not disinterest, it certainly would indicate that we do not have the feeling of getting organized and getting behind the programs of medicine. Now the AMPAC undoubtedly does not represent all of us all the time. I have been privileged in being on the Nebraska MEDPAC Board for several years, and I am sure we have not represented everybody all the time because we haven't represented my personal views, a member of the Board, all the time. So we do need wide support from everyone here.

"On the north wall of our State Capitol Building there is a deep etching that says, 'The salvation of the state is in the watchfulness of the citizen.' As physicians, we are not watching well enough. There are so many things coming up that we must be aware of. Yesterday Roger Mason brought up a point in Reference Committee #3, concerning a very pernicious group of legislative acts coming out of Washington. The so called House Resolution 12053 and the Senate Bill 2994. We have to have people becoming very much aware, and I don't mean the way we have in the past. If we are going to survive as any sort of a private enterprise system of medicine in this country, which incidentally in my opinion does include HMOs because if we're going to talk about pluralistic methods of delivery of health care, we must include every system but not eradicate the present system.

"I have some suggestions to make and I think some of these things can be done. I make this not with criticism for any standing committee or individuals that we have, but in view that we must, as a group, begin to develop thinking which is going to be helpful to us as a whole. The first thing I'm concerned with as a member of the State Board of Health. I'm appalled at the fantastic lack of information and gross misinformation which is held by our State Legislators and other state officials. Recently two gentlemen in this room and I went to see one of the high officials of our state, and it did not take a few seconds of discussion with him to find how little information he had, how much misinformation and all was hearsay. It seems to me if we are going to correct this type of situation, we must attach a physician to every State Legislator in the state and also get some sort of a speaking association with the Governor and his staff so that they might understand what we are doing and we might get some idea of what they are doing. Because I tell you this hearsay is utterly destructive and injurious to all of our institutions. I suggest our Legislative Committee must continue to peruse all new legislation, not only federal but state legislation. One thing we must start doing that we have not done in the past, and that is we must start drafting our own health legislation. We are very vulnerable because we are looked upon as hand-wringing reactionaries. Everyone in the legislative field knows that all they have to do is put up a bill about health, and we come out swinging. We must start taking the initiative in our own health legislation. Here is where we must start, in this House, and we must build up enthusiasm and we must allow it to spread.

"I spoke to members of the Health Planning Committee yesterday, asking them to establish a group of experts in health planning. As a former member of the Comprehensive Health Planning Program, I know that our professional health planners throughout the country have fantastic plans for us. The only way we are going to be able to stand toe to toe with these people to debate the health issues is to have experts from within our society, a group of people who understand what is going on, or I'll guarantee that these people will eat us alive. They have their plans made and if you go in there unprepared, they zap it to you before you have a chance to make corrections in your thinking or even the language which it takes to understand what is going on.

"Another point I want to make, is that we must work harder on membership. We must represent more people. The more votes we represent, the more power we will wield. We must also encourage these younger people in the medical society to participate. We need students and house officers, etc., to join us. Because although many of the younger people are somewhat more liberal than we were at the same time in our education, we have to allow for their points of view and we must use them if we are going to be representative of a broad number of physicians.

"I haven't come here to expound and make a lot of statements. After what I've seen in my pseudo political job, I'm becoming very concerned that until we do get all our members behind us, we are going to have one heck of a time keeping medicine on any form of an even keel. If we keep saying, 'Let Jack do it,' I'm afraid Uncle Sam will keep doing it to us."

The Chair directed that these remarks of Dr. Colon's be referred to the appropriate standing committee, and this was approved by the House.

Dr. McFadden called for approval of the minutes of the first session, and these were approved as printed.

The House was asked for approval of the minutes of the first session of the Board of Councilors, and these were approved as printed.

Reports of the Reference Committees were called for and the following were presented:

Reference Committee #1

Reference Committee #1 considered four reports and one resolution. The Reference Committee submits the following report and recommendations.

(1) ANNUAL AUDIT REPORT

Recommendation:

Mr. Speaker, your Reference Committee recommends approval of the Annual Audit Report as carried in the Handbook. This was approved.

(2) REPORT OF BOARD OF DIRECTORS

Recommendation:

Mr. Speaker, your Reference Committee recommends the approval of the Report of the Board of Directors as carried in the Handbook. This was approved.

(3) REPORT OF THE DELEGATE TO THE A.M.A. CLINICAL MEETING

Mr. Speaker, your Reference Committee recommends approval of the Report as carried in the Handbook with the following recommendations:

Recommendations:

(a) Your Reference Committee wishes to call the attention of the House of Delegates to Resolutions 2 and 9, which were adopted by the A.M.A. House of Delegates which call for the election of Trustees to the A.M.A. at large. This is a new policy in the A.M.A.

(b) Your Reference Committee wishes to point out that Resolutions 35 and 45 call for the profession to conduct peer review and not professional government review.

(c) Your Reference Committee recommends the Executive Secretary of the N.M.A. send a copy of Report C, Board of Trustees and Resolution #21, concerning funding for medical education and research, to the Deans of the two medical schools in Nebraska.

(d) Your Reference Committee recommends a correction be made under Reference Committee C, Report A, Co. on Med. Ed., to read "N.M.A." instead of "A.M.A.;" and under Reference Committee C, Report F, Co. on Med. Ed. and Res. 130, second paragraph to read "we must await the action of the Board," instead of "we must wait the action of the Board."

(e) Your Reference Committee recommends a copy of the Report of Co. on Med. Ed. and Co. on Med. Serv. on Res. 14 (A-73 Nebr.) and 79 (A-73), be sent to all hospital medical staffs in Nebraska.

(f) Your Reference Committee recommends a copy of Report H, of the Board of Trustees, be sent to all members of the Nebraska Hospital Association.

(g) Your Reference Committee recommends Report Q, Board of Trustees, be sent to the Policy Committee to be assigned to the proper committee of the N.M.A.

(h) Your Reference Committee recommends Report X, Board of Trustees, regarding informed consent, be referred to the Policy Committee for possible informed consent for the State of Nebraska and to report back on this matter to the House of Delegates at the 1974, Fall Session.

(i) Your Reference Committee recommends Report DD, Board of Trustees and Resolutions 26, 30 and 60, be sent to the Insurance and Prepayment Medical Care Committee.

Your Reference Committee wishes to commend Dr. John R. Schenken again for his fine report and his discussion at the Reference Committee. This section of the Reference Committee report was approved.

(4) REPORT OF THE EXECUTIVE SECRETARY

Recommendation:

Mr. Speaker, your Reference Committee recommends the approval of the Report of the Executive Secretary as carried in the Handbook with the following additions:

The meeting sites and dates for the N.M.A.'s future Annual and Fall Sessions shall be:

Fall, 1974 — Lincoln, Nebraska
Spring, 1975 — Lincoln, Nebraska
Fall, 1975 — Omaha, Nebraska
Spring, 1976 — Kearney, Nebraska
Fall, 1976 — Lincoln, Nebraska
Spring, 1977 — Omaha, Nebraska
Fall, 1977 — Kearney, Nebraska
Spring, 1978 — Lincoln, Nebraska
Fall, 1978 — Kearney, Nebraska
Spring, 1979 — Omaha, Nebraska
Fall, 1979 — Kearney, Nebraska

These were approved by the House.

(5) RESOLUTION #2 — DRIVER SAFETY LEGISLATION

Resolution #2, submitted by the Saline County Medical Society, read as follows:

WHEREAS physicians are privy to information regarding the total health of patients who may be unable to drive safely because of physical or emotional impairments, and

WHEREAS the law presently does not make provision for the physician to inform the proper authorities, without legal liability, regarding a physically or emotionally ill patient who may create a highway hazard because of his illness, and

WHEREAS it is the duty of the physician not only to protect his patients to the utmost but also to protect the public at large, and

WHEREAS there are already precedents set in the area of informing authorities regarding infectious diseases, venereal diseases and child abuse; therefore be it

RESOLVED that the House of Delegates of the Nebraska Medical Association go on record as supporting the concept of allowing and encouraging the notification, without legal liability, to the Department of Motor Vehicles by physicians when the driving competency of a patient, to a reasonable doubt, is impaired to the point of creating a highway hazard, and be it further

RESOLVED that the Nebraska Legislature be encouraged to pass such legislation at its 1975 session.

Mr. Speaker, your Reference Committee recommends the approval of Resolution #2. This was approved.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITEE #1 AS A WHOLE. This was approved.

Respectfully submitted,
Russell L. Gorthey, M.D.,
Chairman
T. G. Erickson, M.D.
Robert M. Stryker, M.D.

Reference Committee #2

Reference Committee #2 considered two reports and three resolutions. Your Reference Committee submits the following report and recommendations.

(1) RESOLUTION #1 — OPPOSITION TO "HOLD-HARMLESS" CLAUSE IN INSURANCE POLICIES FOR MEDICAL CARE

Resolution #1, introduced by the Lancaster County Medical Society, read as follows:

WHEREAS, an independently arrived-at doctor-patient relationship is essential to high medical care, and

WHEREAS, an integral part of this relationship in the private practice of medicine involves an agreement by the patient to pay the physician's fee, and

WHEREAS, insurance companies, including Blue Shield of Nebraska, have developed and are selling, policies which purport to cover all medical expenses for which reasonable charges are made, and

WHEREAS, they have set themselves up as the exclusive arbiters of what constitutes reasonable charges, and

WHEREAS, this constitutes an indirect, but no less effective, method of one-sidedly setting fees for the practicing physician without his knowledge or consent, and

WHEREAS, these insurance companies are instructing their policy holders not to make any agreement with the doctor in regard to his fee, or their insurance will not be operative, and

WHEREAS, these aforementioned policies contain a "hold-harmless" clause wherein the company agrees to defend in court against any attempt by the doctor to collect any more of his fee than the company deems reasonable, and

WHEREAS, Blue Shield sets itself forth as having had these policies "approved" by the Nebraska Medical Association, and

WHEREAS, these aforementioned factors constitute unwarranted interference in the practice of medicine, and

WHEREAS, there is already in operation a Peer Review mechanism at the state and local level which has very successfully combatted the charging of unreasonable fees; therefore, be it

RESOLVED, that the "hold-harmless" clause should be removed from insurance policies which cover payment for medical care.

The Reference Committee listened to lengthy discussions both pro and con regarding this resolution. Some of the arguments against the resolution were that "hold-harmless" is a method of "putting teeth" into decisions made by peer review and insurance companies. It was thought to be a method of consumer protection. The primary arguments in favor of the resolution were that physicians respect the right of insurance companies to sell any type of policy they desire with any clause they feel necessary, but does the insurance company recognize the right of physicians to contract with patients regarding services performed and fees charged for these services.

It was pointed out that regardless of the pro and con arguments that may be developed at the Reference Committee session, that some of the men testifying felt compelled to disagree with the "hold-harmless" clause and that they had been approached by many of their fellow members and felt it their duty to object to the "hold-harmless" clause.

As a preface to our recommendations, it was thought that it would be necessary to review the previous actions of the Nebraska Medical Association in regard to the "hold-harmless" clause. An extensive search of the transactions revealed the following information. At the May meeting of the House of Delegates in 1972, Resolution #4 from Scotts Bluff County was presented and the RESOLVED portion stated as follows:

"RESOLVED, that the Nebraska Medical Association also endorse the "paid in full concept" and the "hold harmless clause" as defined by the Nebraska Blue Shield and utilized in usual and customary contracts; and"

This was published on Page 308, in the July, 1972, Nebraska Medical Journal.

The House of Delegates supported the Reference Committee to disapprove this because of the "contradictory nature of the resolution as related to concepts adopted by the House in April, 1969, of the Report of the Ad-Hoc Insurance Study Committee."

Also, at the Annual Meeting in May, 1972, the Report of the Interim Study Committee on Blue Shield was reviewed. This was printed on Page 296, of the July issue of the 1972, Nebraska Medical Journal. This report simply called attention to the "hold-harmless" clause and suggested that all doctors be fully aware of what this clause said. As stated in the report, "the Nebraska Blue Shield informed this Interim Study Committee on Blue Shield that the only alternative to participating agreements, was to issue a contract which includes a full-payment concept and a "hold-harmless" clause.

This was essentially the first time that the "hold-harmless" concept was presented to the House of Delegates, since in the Report of the Ad-Hoc Committee on Blue Cross-Blue Shield of 1969, "hold-harmless" did not exist. At this 1972, May meeting, the House accepted the Interim Committee Report as outlined in the paragraph above without any definitive action taken on the "hold-harmless" clause.

Additionally, it was noted that there was a resolution passed in 1969, at the Annual Meeting, by the House of Delegates of the Nebraska Medical Association:

"BE IT RESOLVED, that Nebraska Medical Association emphatically rejects any system which attempts to set fees or fee schedules interjected by person or persons representing a third-party interest."

Lastly, at the October, 1973, meeting of the House of Delegates as reported in the December, 1973, Nebraska Medical Journal, the Nebraska Medical Association House of Delegates supported the resolution passed by the A.M.A. in June of 1973, which was as follows:

"RESOLVED, that the American Medical Association encourage physicians to educate patients regarding their responsibility to the physician. One approach to such education is the use, where appropriate of a 'statement of understanding' such as the following:

STATEMENT OF UNDERSTANDING

I agree that the determination of professional services to be rendered by my doctor and the fees to compensate him for these services are matters concerning my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for his services,

notwithstanding any contract I may have with any third party (be it an insurance company, employer, union, government or the like). Neither my doctor nor I will permit any third party to determine what medical services I need or what fees the doctor should receive in return for these services. Any agreement that either of us may have with any third party shall not affect our doctor-patient relationship and the decisions relating to medical care and fees. Neither my doctor nor I, as his patient, are in any way bound by any contract the other may have with any third party."

After hearing the discussion and after reviewing the past actions of the House of Delegates referable to "hold-harmless" clause, your Reference Committee recommends the following amended Resolution #1 be adopted:

WHEREAS, an independently arrived-at doctor-patient relationship is essential to high medical care, and

WHEREAS, an integral part of this relationship in the private practice of medicine involves an agreement by the patient to pay the physician's fee, and

WHEREAS, insurance companies, including Blue Shield of Nebraska, have developed and are selling, policies which purport to cover all medical expenses for which reasonable charges are made, and

WHEREAS, they have set themselves up as the arbiters of what constitutes reasonable charges, and

WHEREAS, this constitutes an indirect method of setting fees for the practicing physician, and

WHEREAS, these aforementioned policies contain a "hold-harmless" clause wherein the company agrees to defend in court against any attempt by the doctor to collect any more of his fee than the company deems reasonable, and

WHEREAS, these aforementioned factors constitute unwarranted interference in the practice of medicine, and

WHEREAS, there is already in operation a Peer Review mechanism at the state and local level which has very successfully combatted the charging of unreasonable fees; therefore, be it

RESOLVED, that the Nebraska Medical Association go on record as opposed to the "hold-harmless" clause and any similar concept.

Mr. Speaker, I move the adoption of this section of our report. This was approved by the House.

(2) RESOLUTION #8 — OPPOSITION TO PHASE IV PRICE CONTROLS

Your Reference Committee next considered Resolution #8, as presented by the Omaha Medical Society. This resolution is in support of the A.M.A.'s lawsuit against the Federal government's Cost of Living Council as read as follows:

WHEREAS, the American Medical Association on February 19, 1974, filed a lawsuit against the Federal Government's Cost of Living Council, asking for relief from such price controls, on the basis of "unwarranted discrimination in violation of the Fifth Amendment of the Constitution," and that "Phase IV regulations are arbitrary and capricious in violation of the Economic Stabilization Act, the Administrative Procedure Act, and the Fifth Amendment to the U.S. Constitution."

THEREFORE, BE IT RESOLVED, that the Nebraska Medical Association supports the American Medical Association's arguments in objecting to being held under Phase IV price controls, and be it further

RESOLVED, that a copy of this resolution be sent to the American Medical Association, the American Hospital Association, and the Nebraska Hospital Association, the Omaha District Dental Society, and the Nebraska State Dental Association.

There was no testimony heard in opposition to this resolution. During the discussion, the reasons for presentation of this resolution were brought forth and were agreed with by all present.

Recommendation:

Your Reference Committee recommends the following amended Resolution #8 be adopted:

WHEREAS, the American Medical Association on February 19, 1974, filed a lawsuit against the Federal Government's Cost of Living Council, asking for relief from such price controls, on the basis of "unwarranted discrimination in violation of the Fifth Amendment of the Constitution," and that "Phase IV regulations are arbitrary and capricious in violation of the Economic Stabilization Act, the Administrative Procedure Act, and the Fifth Amendment to the U.S. Constitution;"

THEREFORE, BE IT RESOLVED, that the Nebraska Medical Association supports the American Medical Association's lawsuit in objecting to health care costs being held under Phase IV price controls, and be it further

RESOLVED, that a copy of this resolution be sent to the American Medical Association, the American Hospital Association, the Nebraska Hospital Association, the Omaha District Dental Society, the Nebraska State Dental Association, to all Nebraska Senators and Representatives, and to the members of the appropriate Congressional committees considering this issue.

Mr. Speaker, I move the adoption of this section of your Reference Committee report. This was approved.

(3) REPORT OF THE INSURANCE AND PREPAYMENT MEDICAL CARE COMMITTEE

A. L. Smith, Jr., M.D., was present at the Reference Committee session and clarified some points contained in the report. He also suggested it might be well to offer the insurance opportunities available to the members to house officers and medical students who are members, and to Associate Members. This was concurred by everyone present at the Reference Committee session.

Recommendation:

Mr. Speaker, I move the adoption of the Report

of the Insurance and Prepayment Medical Care Committee and recommend that additionally house officers and medical students who are members, and Associate Members be offered the opportunity to participate in the insurance programs as far as possible. This was approved.

(4) REPORT OF THE RELATIVE VALUE STUDY COMMITTEE

The fourth item considered by your Reference Committee #2, was the Report of the Relative Value Study Committee. Again there was considerable discussion regarding this report, however there was no dissent heard that the report should be accepted as far as it goes. It was appreciated by the Reference Committee the obvious amount of effort and untold amount of time that had been spent by this committee in attempting to carry out the task assigned to it by the House of Delegates to revise the 1965 Relative Value Study. Several members of the committee were present including Dr. Orin Hayes, the Chairman of the committee. In assimilating the report with the discussion held at the time of the Reference Committee session, it was the feeling of the Reference Committee that the report should be adopted.

However, there were several problems that became apparent after reading the report and discussion of the report with the members of the committee present. One of the primary problems that the committee ran into was that there was considerable variation in fees for the same code number or procedures as listed by the various specialty societies. It appeared to the Reference Committee as though there were two alternatives to answer this problem:

(a) The committee could act arbitrarily and simply set relative values on all procedures; or,

(b) They could call in the specialty societies and negotiate for relative values.

Recommendations:

1. The Reference Committee agreed in its deliberations with the preponderance of opinion presented that the committee should call in the specialty societies and negotiate for relative values. The question posed in the committee report under Item 3, as to whether the committee is responsible for producing a uniform fee schedule was next given consideration by the Reference Committee and after giving this considerable study, we could find no evidence that the House of Delegates had at any time directed this committee to produce a uniform fee schedule.

2. Therefore, the Reference Committee felt that the Relative Value Study Committee should proceed forthwith in producing a relative value study.

3. It was not felt by the Reference Committee at this time that the question of what the conversion factor should be entered into, but rather that after the instrument was produced the method of implementation and the question of conversion factors could be dealt with by the House at a subsequent session.

Mr. Speaker, I move the adoption of this section of your Reference Committee report. This was approved.

(5) RESOLUTION #5 — NEBRASKA RELATIVE VALUE STUDY

The fifth item considered was Resolution #5, introduced by the Lancaster County Medical Society, on the subject of incorporation of a Cost of Living "escalation clause" in the Nebraska Relative Value Study for purposes of Workmen's Compensation and other third parties, and read as follows:

> WHEREAS, the Nebraska Relative Value Study is used by the Workmen's Compensation Court for the establishment of fees paid in workmen's compensation cases and government related agencies, and
>
> WHEREAS, this fee schedule acts as a ceiling of fees above which charges need not necessarily be paid by the insurance carrier in workmen's compensation cases, etc., and
>
> WHEREAS, the Nebraska Medical Association has been negligent in protecting the interests of its members by not acting for ten years to update this present relative value study and workmen's compensation conversion factor, and
>
> WHEREAS, the presently paid fees are therefore woefully out-of-date and much too low, and
>
> WHEREAS, there is every reason to believe that the Association will not update this study every year and renegotiate a new conversion factor on an annual basis; therefore, be it
>
> RESOLVED, that a Cost of Living "escalation clause" should be incorporated into negotiations with the Workmen's Compensation Court and/or other third parties as a minimum level to which fees may be raised and will be raised on an annual basis.

Members of the Lancaster County Medical Society who presented this, pointed out that for the most part since the introduction of the relative value study and the conversion factor of five in 1965, that there had been essentially no revision in the conversion factor and the two organizations that are presently using this as a basis for payment, which are Workmen's Compensation and Medicaid, are essentially still using the same conversion factor as used in 1965. Further testimony by the officers of the Nebraska Medical Association revealed that essentially there was no direction for the Medical Association to negotiate with Workmen's Compensation or with Medicaid for modification, and if this resolution was adopted, it was their impression the N.M.A. would be so instructed to do so on a regular basis. There was some discussion as to the advisability and correctness of the second, third, fourth and fifth WHEREAS's.

Recommendation:

Therefore, your Reference Committee suggests that Resolution #5 be modified to read as follows:

> WHEREAS, the Nebraska Relative Value Study is used by the Workmen's Compensation Court for the establishment of fees paid in workmen's compensation cases and government related agencies; therefore, be it
>
> RESOLVED, that a Cost of Living "escalation clause" should be incorporated into nego-

tiations with the Workmen's Compensation Court and/or other third parties as a minimum level to which fees may be raised and will be raised on an annual basis.

This was seconded, and considerable discussion followed concerning the RESOLVED portion of this modified resolution. Motions were made to change the words, "escalation clause" to "adjustment clause;" delete the word, "minimum;" and change the words "raised" to "adjusted." These motions were approved, and the amended RESOLVED would read as follows:

RESOLVED, that a Cost of Living "adjustment clause" should be incorporated into negotiations with the Workmen's Compensation Court and/or other third parties as a level to which fees may be adjusted and will be adjusted on an annual basis.

Mr. Speaker, I move the adoption of this section of your Reference Committee report as amended. This was approved.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #2, AS A WHOLE AS AMENDED. This was approved.

Respectfully submitted,
C. Lee Retelsdorf, M.D.,
Chairman
P. B. Olsson, M.D.
Edwin J. Loeffel, M.D.

Reference Committee #3

Reference Committee #3 considered two reports and two resolutions and submits the following report and recommendations.

(1) REPORT OF THE HEALTH PLANNING COMMITTEE

Your Reference Committee first considered the Report of the Health Planning Committee and heard minimal discussion regarding same.

Recommendation:

Mr. Speaker, your Reference Committee recommends approval of this report. This was approved.

Your Reference Committee wishes to encourage the members of the House to fill out the survey form which was included in the Handbook regardless of specialty, or type or location of practice. Your Reference Committee would also like to encourage the membership of the N.M.A. and the members of the House of Delegates in particular to refer in writing any item of concern and any suggestions which they might have to the Health Planning Committee whose Chairman is Dr. Richard A. Cottingham, McCook, Nebraska.

(2) RESOLUTION #6 — REPEAL OF PSRO

Your Reference Committee next considered Resolution #6, from the Omaha Medical Society, as amended on the floor of the House in the First Session, and which reads as follows:

WHEREAS, "assessing the viability" of an effort to repeal PSRO is a fruitless effort before the public and the federal legislators are informed of its deleterious effects, and

WHEREAS, the medical profession is already operating under Utilization Review and Peer Review programs in order to monitor quality of care and proper uses of services and facilities; therefore be it

RESOLVED, that the Nebraska Medical Association and all component societies work vigorously for repeal of the PSRO provisions of PL-92-603; Sections 249F, 229, 207, 213, and any other objectionable regulatory controls which interfere with the practices of medicine; and be it further

RESOLVED, that a suitable resolution be prepared requesting the A.M.A. to work vigorously for repeal of PSRO in order to provide leadership to its component societies; and be it further

RESOLVED, that a major thrust of the A.M.A. effort be to inform the public and the federal legislators of the potential deleterious effects of the law on the quality, confidentiality, and cost of medical care.

Recommendation:

Mr. Speaker, your Reference Committee recommends approval of this Resolution #6. This was approved.

(3) RESOLUTION #4 — OPPOSITION TO PSRO

Your Reference Committee next considered Resolution #4, from the Lancaster County Medical Society, which read as follows:

WHEREAS, PSRO has been assessed by Nebraska Medical Association and by other state medical associations as being impractical and unworkable and deleterious to quality medical care, and

WHEREAS, Nebraska Medical Association and several other state medical associations and the American Medical Association and AAPS have declared for repeal of PSRO; therefore be it

RESOLVED, that Nebraska Medical Association reaffirms its commitment to the concept of effective and meaningful peer review, and be it further

RESOLVED, that Nebraska Medical Association once again vigorously through the news media and through any other effective channels restate its position on repeal of PSRO provisions of PL 92-603, and be it further

RESOLVED, that the Nebraska Medical Association peer review program as now organized and constituted serve in the stead of PSRO, emphasizing and safeguarding local physician autonomy, and be it finally

RESOLVED, that with full implementation of a genuine and superior peer review program, Nebraska Medical Association will now discontinue planning efforts in behalf of the federal PSRO initiative in Nebraska.

Recommendation:

Your Reference Committee recommends that this resolution be amended by deleting the last two RESOLVED's, and adding the following:

RESOLVED, that the Nebraska Medical Association strengthen and improve the peer review program presently functioning with additional emphasis on the educational aspects of its activity.

Mr. Speaker, your Reference Committee recommends approval of this Resolution #4, as amended. This was approved.

(4) REPORT OF THE AD-HOC COMMITTEE ON PSRO

Recommendation:

Your Reference Committee recommends that this report be accepted for information and that the committee be commended for their diligence and comprehensive study of this problem on behalf of the Nebraska Medical Association.

We further recommend that the Ad-Hoc Committee on PSRO be continued and that this committee continue to explore contingency plans regarding PSRO in the event that repeal of PSRO is not accomplished.

Mr. Speaker, your Reference Committee recommends adoption of this section of its report. This was approved.

For the information of the House, the following amendments will be offered by the A.M.A. Board of Trustees either May 8th or 9th, to the Talmadge Senate Health Committee:

1. Foundations designated by medical societies should be considered as PSROs.
2. Suggest that the time limitation for position groups which presently expires January of '76 be extended to July of '78.
3. The part of the law that states that the guidelines developed which describe norms, criteria and standards be guidelines only and not be substituted for individual personal judgement.
4. That the authority presently existing in the law requiring pre-admission certification be deleted.
5. Recommend that the review of patient and provider profiles not be on a case by case basis but only on a sample basis.
6. Recommend that the section which provides for financial penalties should be changed to provide for a system of graduated sanctions. (Suspension from program for x number of days).
7. The section in the law which now requires that violations must be forwarded to the State PSRO to in turn be forwarded to HEW be amended to state that this will only be done when the local PSRO determines same. (Handle these at local level).
8. Confidentiality — recommend that written records of a PSRO shall not be subject to subpoena in civil actions.
9. Recommend that section #1167 which limits the professional liability of the individual who has complied with the norms of care (this is considered due care and conduct on which malpractice cases are based) should be absolutely deleted.
10. The law should be amended to clearly state limited functions of norms, criteria and standards so that the physician could use his own professional judgment.
11. The section which described reimbursement of PSRO expenses is too vague — should be amplified to relate exactly what PSRO will be reimbursed for.
12. Amendment to provide for an orderly appeal of area designations.
13. An amendment to extend PSRO to all government programs.
14. Repeal section 1155B4, which authorizes a PSRO to inspect facilities under which care is rendered (duplication of existing facilities).
15. Repeal of section 1155B3, which provides that a doctor must maintain records which prove quality of care, etc. This is redundant, abusive and jeopardizes confidentiality.
16. Proposing that the law be altered to state that the government must enter into direct contracts with medical societies for assistance to the PSROs. (The law uses the word "can" rather than "must").
17. Section 213 — This section states that noncovered services under the Medicare Program can be recovered by the government from the provider rather than the patient. This section should be repealed.
18. All provisions regulating utilization review committees are now described under the Medicaid law. This is redundant and should be deleted.
19. Section 229 — The authority to create a program of review of the teams should be repealed in that it is redundant.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #3 AS A WHOLE. This was approved.

Respectfully submitted,
Carl J. Cornelius, Jr., M.D., Chairman
F. H. Hathaway, M.D.
Richard A. Cottingham, M.D.

Reference Committee #4

Reference Committee #4 considered one report, one resolution and the applications of request for Life Memberships. Your Reference Committee submits the following report and recommendations.

(1) LIFE MEMBERSHIPS

The following requests for Life Membership were considered:

Burton R. Bancroft, M.D., Kearney
David Bloch, M.D., Arlington
H. C. Anderson, M.D., Grand Island
C. D. Bell, M.D., Lincoln
Ruth A. Warner, M.D., Minden
O. C. Kreymborg, M.D., North Platte
John E. Courtney, M.D., Omaha
J. H. Judd, M.D., Omaha
Ben Slutzky, M.D., Omaha
W. Max Gentry, M.D., Gering
Van H. Magill, M.D., Curtis
Arnold J. Mullman, M.D., Oakland
Lloyd N. Kunkel, M.D., Weeping Water

Recommendation:

Reference Committee #4 wishes to recommend the applications for Life Membership as listed.

Mr. Speaker, I move acceptance of this section of your Reference Committee report. This was approved.

(2) RESOLUTION #7 — UNL HEALTH SERVICE PROGRAM

Your Reference Committee next considered Resolution #7, dealing with the University of Nebraska-Lincoln, Health Service Program, which read as follows:

WHEREAS, the students at the University of Nebraska-Lincoln have enjoyed the privilege of high quality medical service, and

WHEREAS, this health program has as its primary goal the concept of health maintenance and prevention of illness and injuries, and

WHEREAS, the present health program is threatened with fractionation which would result in placing segments of the health services under non-medical control and lead to the needless destruction of the present unique program of health care, including the elimination of the multidisciplinary medical clinic, and

WHEREAS, this controversy has already resulted in the resignation of key medical staff members that have served the University of Nebraska for many years, and

WHEREAS, the medical staff of the University of Nebraska Health Center in Lincoln is in complete agreement with the goals and objectives of the original comprehensive health program of the University Health Center which was further supported by a report, dated March 3, 1973, of a special task force appointed to review the organization of the University Health Center and accepted by the Board of Regents that included the statements, "To fragment that program would destroy the capability to achieve the goals of health maintenance and prevention of injury and illness, would markedly escalate the cost of the separate parts of a comprehensive health program, and would destroy the efficient and maximum utilization of health personnel. Therefore, the Medical Staff rejects the concept of fragmentation of the University Health Center program and wastage in funds and personnel. The Medical Staff strongly approves of the leadership of the present professional staff which has been asked to accomplish the difficult task of providing a comprehensive health program of high quality in a most inadequate facility, with inadequate funds, and lack of appropriate and qualified administrative assistance;"

THEREFORE BE IT RESOLVED, that the Nebraska Medical Association endorse the concept that all health services provided at the University Health Center should continue to be medically oriented and physician directed and controlled, and

BE IT FURTHER RESOLVED, that in order to achieve maximum economy in operation, to efficiently utilize the health resources and personnel and to maintain the highest quality of medical services possible, unification of health resources is crucial and essential and that this be accomplished by transferring the responsibility for the University of Nebraska Health Center in Lincoln, including the on-going health programs, from the control of the Chancellor of the University of Nebraska-Lincoln to the control of the Chancellor of the Medical Center, and

BE IT FURTHER RESOLVED, that a copy of this resolution be forwarded to the Board of Regents of the University of Nebraska for implementation.

Recommendation:

Following much discussion in committee, the Reference Committee wishes to revise the resolution as follows:

WHEREAS, the students at the University of Nebraska-Lincoln have enjoyed the privilege of high quality medical service, and

WHEREAS, this health program has as its primary goal the concept of health maintenance and prevention of illness and injuries, and

WHEREAS, the present health program is threatened with fractionation which would result in placing segments of the health services under non-medical control and lead to the needless destruction of the present unique program of health care, including the elimination of the multidisciplinary medical clinic; therefore be it

RESOLVED, that the Nebraska Medical Association endorse the concept that all health services at the University Health Center should continue to be medically oriented and physician directed and controlled, and be it further

RESOLVED, that in order to achieve maximum economy and operation to efficiently utilize the health resources and personnel and to maintain the highest quality of medical services possible, unification of health resources is crucial and essential, and that the possibility of transferring the responsibility for the University of Nebraska Health Center in Lincoln, including the ongoing health programs from the control of the Chancellor of the University of Nebraska-Lincoln to the control of the Chancellor of the Medical Center be studied, and be it further

RESOLVED, that the President and Policy Committee of the Nebraska Medical Association be strongly encouraged to accept the offer of Chancellor Zumberge to meet and discuss possible means of resolution of these problems.

Mr. Speaker, I move acceptance of this section of your Reference Committee report. This was approved.

(3) REPORT OF THE POLICY COMMITTEE

Your Reference Committee next considered the Report of the Policy Committee as contained in the Handbook.

Recommendation:

Your Reference Committee wishes to endorse and accept the Report of the Policy Committee as written. In addition, the Reference Committee would recommend with any further deliberations between the Nebraska Medical Association and the officials of the University of Nebraska at Lincoln regarding health services, that the concepts of right to privacy, preservation of physician-patient relation-

ship, confidentiality of medical records, and the continuing high degree of quality medical care be emphasized.

Mr. Speaker, I move acceptance of this section of your Reference Committee report. This was approved.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #4 AS A WHOLE. This was approved.

Respectfully submitted,
Fred J. Rutt, M.D., Chairman
R. C. Weldon, M.D.
John C. Goldner, M.D.

Reference Committee #5

Your Reference Committee considered three reports and one resolution, and submit the following report and recommendations.

(1) REPORT OF THE PUBLIC RELATIONS COMMITTEE

Your Reference Committee commends the Public Relations Committee in its attempt to portray medicine and the physician in a "positive" light. The new documentary film, "But For the Grace" is evidence of the continuing activities of the committee.

Recommendation:

Mr. Speaker, your Reference Committee recommends that the Public Relations Committee continue in its philosophy of presenting medicine and the physician in a positive light and recommends the approval of the report as carried in the Handbook with commendation to the committee for its efforts. This was approved.

(2) PROGRESS REPORT OF THE NEBRASKA REGIONAL MEDICAL PROGRAM

Your Reference Committee notes the continued, but tenuous survival of the Nebraska Regional Medical Program. The future of the program would seem to depend entirely upon the legislation now pending in Congress.

Recommendation:

Mr. Speaker, your Reference Committee recommends the acceptance of the report for informational purposes as it is carried in the Handbook. This was approved.

(3) RESOLUTION #3 — EMERGENCY MEDICAL COMMUNICATIONS

Discussion before your Reference Committee concerned the difficulties in establishing a clearing or coordinating center for emergency medical services in Nebraska in contrast to some areas where the 911 Telephone System is on a state-wide basis. Nebraska is serviced by a number of telephone companies. Each company must be made aware of the fact that the 911 Telephone System is important in providing emergency medical service so that more efficient utilization of telecommunication between areas may be accomplished.

Resolution #3, submitted by the Saline County Medical Society, read as follows:

> WHEREAS, the state of medical communications in Nebraska, as regards Emergency Medical Services, is presently in a state of disarray with many localities having communications equipment but no clearing or coordinating center to enhance their effectiveness, and
>
> WHEREAS, it behooves the State of Nebraska to have an efficient system of communications for the ill and injured being transferred from place to place in the state; therefore be it
>
> RESOLVED, that the House of Delegates of the Nebraska Medical Association go on record as being in support of a study which would bring to light methods to facilitate telecommunications and establish a system of coordinating communications centers, and be it further
>
> RESOLVED, that the Nebraska Medical Association go on record as supporting the concept of the 911 telephone system as the access to emergency services throughout the state.

Recommendation:

Your Reference Committee recommends that the Resolution #3 be amended by the addition of the following:

> RESOLVED, that a copy of this resolution be forwarded to the Governor of the State of Nebraska, the Director of the State Department of Health, and appropriate health-planning organizations in Nebraska.

Mr. Speaker, your Reference Committee recommends approval of Resolution #3 as amended. This was approved.

(4) REPORT OF THE MEDICAL EDUCATION COMMITTEE

The Nebraska Medical Association supports the concept of voluntary continuing education for its members. Your Reference Committee notes that the Medical Education Committee is requesting authorization "to work on details for further implementation of such a program and a recognition certificate" with approval of this report.

Discussion before your Reference Committee focused on the problem of adequate funding of graduate medical education. Currently, these programs are largely funded by additions to the daily bed charge of the hospitals. We concur that methods of alternate sources of financing be explored.

Included as a portion of the Report of the Medical Education Committee is a resolution concerning greater communication and liaison between the administration of the two medical schools in Nebraska and the Nebraska Medical Association.

Recommendation:

Your Reference Committee recommends that the resolution be amended as follows:

> WHEREAS, there are areas in Nebraska where increased physician coverage would be desirable, and
>
> WHEREAS, there are areas in Nebraska where additional specialists in some fields of medical practice would be desirable, and
>
> WHEREAS, the University of Nebraska College of Medicine and the Creighton University School of Medicine have established goals in an attempt to provide these physicians and to set up cooperative patterns of health care between areas in Nebraska and the Universities; be it therefore

RESOLVED, that the Nebraska Medical Association support these objectives and goals of the two Universities, and be it

FURTHER RESOLVED, that the Nebraska Medical Association and the Universities increase their communication with each other, and be it

FURTHER RESOLVED, that the Nebraska Medical Association work with the Universities in assisting them in gaining adequate financial support to strengthen the schools.

Mr. Speaker, your Reference Committee recommends approval of this resolution of the Medical Education Committee as amended. This was approved.

Mr. Speaker, your Reference Committee recommends the approval of the report of the Medical Education Committee as carried in the Handbook. This was approved.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #5 AS A WHOLE. This was approved.

Respectfully submitted,
Harlan L. Papenfuss, M.D., Chairman
James G. Carlson, M.D.
Myron E. Samuelson, M.D.

Dr. Kenton Shaffer, House Officer Delegate, University of Nebraska, was granted permission of the floor for the following remarks:

"I believe this medical association and especially this House of Delegates, is seeing the tip of an iceberg beginning to surface in our state. We have heard Dr. Kugel and Dr. Colon and various Reference Committees.

"I believe all are now aware of various external influences involved in the practice of medicine. The regents, the administrators, and the legislators are becoming increasingly involved in health related problems.

"The problems of the UN-L Health Center have been discussed at length in this session and the N.M.A. has found itself in an awkward position. The involvement of these external influences at UNMC in Omaha have resulted in the resignation of several faculty members and even a lawsuit for interfering with the rights to practice medicine. Apparently these same influences have been active at the Dental College at UN-L campus.

"The public through their legislators also have been a growing external influence. All of us, I believe, would agree that because it is the public we serve, they have a right to be heard. But is it in their best interest to have a doctor in 'my town.' I have observed this concern play a major role I believe in increasing the number of medical students substantially. Realizing the way to attract young physicians to practice in Nebraska was to have them train here, I have seen the House Officer programs increase faster than have the facilities and faculty for their training. Presently there are projections for having approximately 360 House Officers at the UNMC and over 120 House Officers at Creighton in several years. All of us realize, I think and hope, that this projection is unreal! The role of health care planning by our medical schools? Does it agree with the practice physician concepts? Does anyone realize the goals for the future?

"We as physicians are trained to deliver medical care . . . to care for our patients. Therefore, I believe, we as physicians must be involved as a group with health care now and for the future.

"I see the N.M.A. as an organization to assure quality patient care, i.e. good medical care, patient-doctor relationships, the rights of our patient, etc. Unfortunately, or perhaps fortunately because of the increasing public interest and the ever increasing amount of external influences involved in determining the direction of medicine now and in the future in this state, our ability to assure the quality of care is becoming more difficult. Our state is not unique as this is a phenomenon that is occurring as you know on a national level.

"Presently several committees of the N.M.A. in my opinion are beginning to address themselves to these problems . . . but at this point independently. The Health Care Planning Committee interestingly has no members from the medical schools . . . both of which are attempting to solve problems . . . the same problems often that this committee is attempting to solve. The Medical Education Committee states that the N.M.A. needs to take increasing responsibility in the area of education.

"The N.M.A., I believe, needs to assist in the coordinations of the efforts of the medical colleges and external influences to assure the quality of patient care now and in the future. This of necessity will mean we will need to give our opinions (the opinions of physicians of Nebraska) more actively and more openly.

"Mr. Speaker, I recommend to this House of Delegates that they direct the President of this Association and the Policy Committee to take an increasingly active and vocal role in assisting and guiding these various bodies in planning in such a fashion to assure the future care of our patients."

This recommendation was approved by the House, and the Chair directed that these remarks be a part of the official minutes.

There being no further business, the House was recessed until Wednesday morning for its final session.

Report of House of Delegates

Third Session

The third session of the House of Delegates was held May 1, 1974. The meeting was called to order by the Speaker, Dr. Harry McFadden.

The call for a quorum showed 50 delegates present, and the House was declared in session.

Oral reports were presented by the following:

Mrs. Warren Bosley — Immediate Past President, Woman's Auxiliary to N.M.A.

Dr. Frederick Paustian — Medical Service Plan at the UNMC

Dr. Ralph L. Wicks, President of the Iowa Medical Society, was introduced to the House for a few brief remarks.

Dr. McFadden called for approval of the minutes of the second session of the House, and these were approved as printed.

Approval of the minutes of the second session of the Board of Councilors was called for, and these were approved as printed.

Dr. McFadden called for the report of the Nominating Committee, and Dr. James Carlson, Chairman, presented the following slate of officers:

President-Elect — Dr. Warren G. Bosley, Grand Island

Speaker, House of Delegates — Dr. Harry McFadden, Jr., Omaha

Vice Speaker, House of Delegates — Dr. Chas. Landgraf, Jr., Hastings

Councilors:

9th District — Dr. Hiram Walker, Kearney
10th District — Dr. Fred J. Rutt, Hastings
11th District — Dr. Berl Spencer, Ogallala
12th District — Dr. Calvin Oba, Scottsbluff

Delegate to A.M.A. — Dr. John R. Schenken, Omaha

Alternate Delegate to A.M.A. — Dr. John D. Coe, Omaha

Delegate to North Central Medical Conference — Dr. Russell L. Gorthey, Lincoln

There being no further nominations from the floor, the House approved the slate of officers presented by the Nominating Committee.

Dr. Schenken was granted permission of the floor at which time he called attention to the Digest of Official Actions which is prepared by the A.M.A. He stated that he would like to recommend that the N.M.A. also prepare a digest of the official action of the House of Delegates. This was approved by the House.

Dr. Westbrook was granted permission of the floor and moved that a poll of all the physicians in Nebraska be taken by the N.M.A. office to determine how many physicians will stand firm in their opposition to and refusal to participate in any system or legislative form of medical care which does not include the following three provisions:

1. The patient's right to free choice of physician.
2. Physician's right to bill his patient directly for services rendered.
3. The right of the physician and the patient acting together as the only authority in determining the proper care and treatment of the patient.

This motion was seconded, and Dr. Retelsdorf moved that this be amended by referring this to the Policy Committee for discussion and to be brought back to the next session of the House. This was approved by the House.

There being no further business, the House was adjourned.

Treatment of Recurrent Nephrolithiasis With Cellulose Phosphate — C. Y. C. Pak et al (5323 Hines Blvd. Dallas 75235). New Eng J Med 290:175-180 (Jan 24) 1974.

Sixteen patients with absorptive hypercalciuria and nephrolithiasis underwent prolonged treatment with cellulose phosphate (5 gm two or three times daily, orally). The usual responses were a decrease in urinary excretion of calcium, usually to values below 200 mg/day, and a decrease in the state of saturation of urine with respect to brushite (the nidus of calcium stones), often from supersaturation to undersaturation. Clinically, renal stone formation virtually ceased. The treatment was well tolerated, and no significant side effects were observed. Serum concentration of parathyroid hormone and bone density by ^{125}I-photon absorption did not change considerably or remained within the normal range. Thus, in these patients with an enhanced intestinal absorption of calcium, hypercalciuria may be corrected and stone formation prevented by a low-calcium diet and inhibition of calcium absorption with cellulose phosphate.

Indirect Blood Pressure Measurement in Newborns — H. S. Dweck et al (Dept of Pediatrics, Univ of Alabama, Birmingham 35294). Am J Dis Child 127:492-494 (April) 1974.

Indirect blood pressure measurements in neonates, performed with a Doppler ultrasound instrument, correlated well with direct measurements of arterial pressure in 495 comparisons. Results obtained by medical and nursing personnel, who had little experience with the method, approached the accuracy achieved by experienced observers, and were within clinically acceptable limits.

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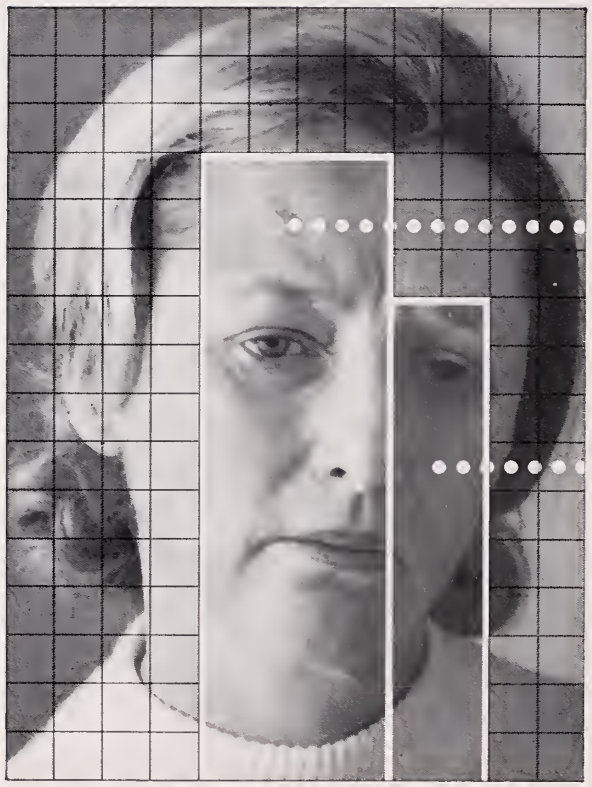

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

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For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

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in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The Nebraska Medical Journal

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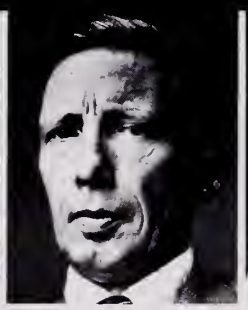

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Letters to the Editor submitted for publication should be prepared as above, and must carry the notation: To be Published.

Reprints should be ordered from the printer, Norfolk Printing Co., Inc., P. O. Box 278, Norfolk, Nebr. 68701.

Our Medical Schools . . .

Dr. Bartone to England

Dr. Francis F. Bartone, chairman of the Department of Urology at the U of N, has been appointed a senior research assistant in pediatric urology in the Department of Child Health at the University of Liverpool. He will take a six-month sabbatical leave to study in England beginning July 1.

As a fellow of the university, Dr. Bartone will have an opportunity to conduct urological research in pediatrics and observe the clinical care of pediatric patients with urological problems. He will return to the University of Nebraska Medical Center at the end of the year.

Medicinews . . .

First PSRO contract signed

The Utah Professional Standards Review Organization has been awarded a $950,000 contract to conduct PSRO review functions over the next 18 months. The Utah organization, which has been operating for almost 3 years, has now become the nation's first conditional PSRO. The Department of HEW has announced that 100 additional contracts will be executed before the end of June. Of these contracts approximately 12 will be for actual conditional PSRO's. The remainder will be planning grants and PSRO support center contracts.

Hypnosis in Treatment of Warts — O. S. Surman et al (T. P. Hackett, Massachusetts General Hosp, Boston 02114). Arch Gen Psychiatry 28:439-441 (March) 1973.

Seventeen experimental patients with bilateral common or flat warts were hypnotized weekly for five sessions and were told that the warts would disappear on one side only. They were reexamined three months from the time of the first hypnotic session. Seven patients who were untreated were also reexamined at the end of three months. Fifty-three percent of the experimental group improved. No improvement was observed among untreated controls.

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Radiation control hearings

The Senate Health Subcommittee has conducted hearings on S. 667, the Radiation Control for Health and Safety Act. The bill would provide federal minimum standards for the training of radiologic technologists, accreditation standards for training schools, and the licensure of radiologic technologists. Similar legislation, H.R. 673, is pending in the House. Speaking on behalf of the Administration, Charles C. Edwards, M.D., Assistant Secretary for Health, opposed the enactment of the bill. Dr. Edwards proposed that PSRO's be utilized as the appropriate vehicle for assuring the quality and necessity of x-ray services. He further praised the AMA accreditation program for schools of radiologic technology calling the AMA criteria "adequate to insure reasonable quality of education." Continuing Dr. Edwards said, "We thus feel that the mandating of federal accreditation criteria (as called for in S. 667) to be imposed by the 50 states is both unnecessary and undesirable. It is our belief that current accreditation procedures being carried out on a voluntry basis are adequate. We regard the licensing and credentialling of allied health professions and health professionals generally as a legitimate State responsibility, perhaps under a non-Federal national framework of common policies and approaches."

The American College of Radiology was represented by James P. Steel, M.D., past vice president, who outlined the advantages and disadvantages to public licensure of radiologic technologists. He said the present experience was insufficient to support the repeal of state laws or the adoption of a national system. "We think that radiologists, technologists, the AMA and the Department of Health, Education and Welfare should move promptly to assessments of impacts of these state programs before seeking action by the Congress," he said.

I look into my glass,
And view my wasting skin,
And say, 'Would God it came to pass
My heart had shrunk as thin!'

Thomas Hardy

"I changed my mind!"

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Clinical Course and Prognosis of Myocardial Infarction in Hypertensives — O. A. Beck (Rudolf Virchow Krankenhaus, Berlin) and H. Hochrein. Dtsch Med Wochenschr 99:815-820 (April 19) 1974.

Of 609 patients with acute myocardial infarction, 285 (47%) had demonstrable arterial hypertension. This group was contrasted with another one consisting of 324 patients with infarct but without hypertension. Hospital mortality among hypertensives after acute myocardial infarction was significantly higher (37.2%) than that among normotensives (24.4%). The hypertensive patient with infarct was much more prone to hemodynamic complications, especially severe heart failure (80.4% compared to 6.18%) with combined right-left heart failure and pulmonary edema. Preexisting heart damage and previous infarction were especially lethal for hypertensives. Atrial fibrillation and flutter were significantly more frequent in hypertensive patients with infarct, while ventricular fibrillation and flutter were more common in normotensives. The higher mortality among hypertensives applied both to transmural and nontrasmural infarcts, and was especially high among men and patients in the seventh decade. The mean age at time of infarction was 67.9 years in the hypertensive group and 63.5 years in the normotensive one.

New Device for Management of Postnasal Epistaxis by Balloon Tamponade — M. Bell et al (100 College St, Toronto). Arch Otolaryngol 99:372-374 (May) 1974.

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The Role of the Detail Man

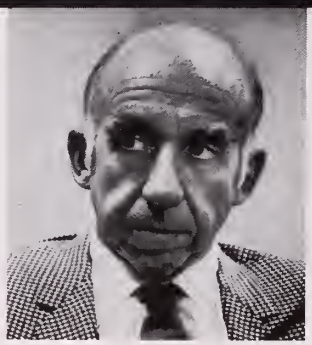
Opinion & Dialogue

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date inforrnation about his products.



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"In the total picture of dealing with health problems in this country, there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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THE TREATMENT OF CANCER OF THE BREAST

How shall we treat cancer of the breast?

One out of every 15 to 20 women in the United States will develop breast cancer. Simple removal of the tumor or of the breast yielded to radical mastectomy in Halsted's day, and even supraradical surgery has been considered. But it has now been suggested that radical operation may not be the method of choice.

If radical surgery was found to be an advance over simpler procedures, and if simple operations were shown to be inadequate, how can a return to conservative surgery now be held to be progress?

And how can scientific observers perform large-scale statistical analysis and reach opposing conclusions?

Treatment has depended on localization and size of the tumor, age, node involvement, grade of malignancy, delay, and metastases. Therapy has included radical mastectomy, radiation, hormones, immunology, steroids, chemicals, oopharectomy, adrenalectomy, supraradical mastectomy, hypophysectomy, ovarian radiation, radioisotopes, supervoltage, local excision, and simple mastectomy.

Should the patient decide? In one city, she is likely to undergo radical surgery; in another, she may have a conservative procedure.

As I write this, the American College of Surgeons has not officially taken a position concerning the controversy regarding the desirable operative procedure to be used in cancer of the breast.[1] The American Cancer Society has taken a clear position. The American Medical Association has not taken a stand on the issue of the optimal surgical treatment of breast cancer.[2]

—F.C.

1. Personal Communication, December 3, 1973.
2. Personal Communication, December 20, 1973.

THE APARTMENT SYNDROME

A Chinese restaurant syndrome has been described, in which the illness is attributed to the ingestion of monosodium glutamate contained in the food. I had the doubtful distinction of eating a rather large portion of soup for my lunch, after which I felt unwell. One of the symptoms was a general sensation of being acutely unhealthy, centering in the chest, but the other was a feeling that my head was about to burst and go away. Neurotoxic effects of glutamate have been demonstrated.

My soup was canned; I took down other specimens from my cupboard and read the labels. Each contained monosodium glutamate. I went to different groceries and pored over labels on different kinds of easy-to-prepare foods. I found that most soups contain monosodium glutamate. Then I looked at frozen or TV dinners, and found the same thing; so did packaged and frozen fish. Unfortunately, some of the foods that did not list MSG on the package referred to such things as spices and flavorings, and I wonder what they are.

The syndrome has been described by observers in restaurants, but I wonder how often it is encountered in the home. For we may be on a steady diet of MSG and not know it, and we may be unable to escape. As for the dose, I do not know how much there is in each package, but if that is what I had, it was enough for me. I have taken refuge in eating things that are not said to contain MSG, but they are not said *not* to contain it, and I do not know what spices and flavors are, or all those other "ingredients," listed by chemical names.

Are we all being subjected to the disease, if we eat canned soups and frozen dinners? I suggest that those who package and sell prepared foods use less MSG or none, or tell you exactly how much there is in what they sell, and that they realize that you may consume glutamate for your lunch and eat more of it with your dinner. I agree, canned soups and TV dinners are as good as women can

cook, but getting the apartment syndrome is something else.

—F.C.

THE DISABLED DOCTOR

The effect of disability depends on the patient. A finger injury may be felt only slightly by a lawyer, but it can be disastrous for a violinist; and a back strain will affect a poet and a furniture mover differently.

Doctors work with their hands a great deal, but not always. Two hands are needed for anesthesiology and for surgery. But a hand disability may not interfere greatly with the practice of psychiatry or dermatology. You might not be able to engage in cardiology if you cannot hear, but visual acuity may not be too important. If you are obese, you can treat patients in any specialty, unless you suffer from the Pickwickian syndrome and keep falling asleep.

A blind physician can practice medicine if he is a psychiatrist or a cardiologist. A doctor may be deaf, and practice radiology. A lame M.D. can be a clinician. A wheelchair-based doctor can practice anesthesiology.

These things have happened, and specialties have been changed when illness or injury proved disabling in one career while another could still be pursued. For a tremor may keep you from being a surgeon, but not prevent you from treating children. And psychiatry may be a refuge for the doctor who cannot stand, or see, or have the use of two hands.

It is sobering to realize that we are laborers, and that while we must use our heads, we work with our hands. Still, it is good to know that when disability strikes, we can change specialties and go on practicing medicine. If you are color-blind, you may not want to use a colorimeter, but there are other things you can do.

—F.C.

WHAT GOOD IS THE HISTORY?

A symptom is what brings the patient to the doctor. He may toy with it for a while and wait for it to go away, or it may get worse and become ominous. The patient has two difficulties: he does not know what is abnormal and reminds you that he is not a doctor, and he cannot tell you what he feels. This is a matter of words, and of our own failure to define and to describe symptoms properly. None of this is related to medical training, for we employ the same nondescriptive terms our patients use. And when we are done with our interview, we often do not understand what the patient has told us.

If he says he has lost weight, this is measurable, it is both a sign and a symptom. If he tells us that he bleeds or coughs, we understand him perfectly. But what does lightheaded mean? I do not know, and the patient does not know; and when the patient says that he is lightheaded, I do not think the physician understands him. When the patient says that the blood rushes to his head, it is likely that no blood rushes to his head, and more than likely that blood has rushed *from* his head. He may tell us of a smothering sensation, or say that he cannot get his breath, he may feel his heartbeat or think that it is going to stop beating.

If he complains of dizziness, we do not know exactly what he means; it suggests that he may fall, but he does not mean that. And he may speak of vertigo, which is not dizziness. If he feels faint, we may not understand him. He may say that he is tired, or run down, or giddy, or weak, or unwell; and a language barrier has been erected between us.

Is the fault ours? It may be, for we have failed to describe symptoms we encounter every day, and we may pretend to understand the patient when we do not. And in our own striving for elegance, we invent a word like malaise.

I feel warm, or cold all over, I hear bells, we are told. My leg is numb, and it sort of hurts. The numbness the patient describes is often not numbness at all, but what does he mean, and what kind of hurting is that? What good is taking a history if we do not understand the patient?

—F.C.

OUR DUES

Here is a condensation of the annual dues of the active members of all the other state medical associations. There are 51 figures, for the remaining 49 states, and for the District of Columbia and for Puerto Rico.

Range:
- Low ..... $ 65.00
- High $450.00

Mean, or average:
- Add them all up, and divide by 49 ..... $125.80

Mode:
- The commonest value in a series $125.00

Median:
- The middle value in the series $122.00

Here is Nebraska $100.00

We are below the mean or average, below the mode, and below the median; or below all the kinds of averages there are, but we are close to the middle.

—F.C.

IS PUS GOOD FOR YOU, OR IS IT BAD?

If you have pus coming out of your ears, it is bad, and the eye is no better, nor is your leg. But pus is just leukocytes and the thin liquor puris, or white cells and serum. Pus can be thick or thin and scanty or copious. It can be almost any color, the usual off-white, and blue or green or cheesy and even bloody.

Our predecessors knew that pus wasn't all that good, even though they spoke of laudable pus, which they called "good and laudable," because it meant that some kind of healing was coming. They must have known about the white cells, and what they were doing. They described foul pus, and burrowing pus, and anchovy sauce pus. And there is sterile pus.

The older doctors saw more pus than we do, because they didn't have antibiotics; so they may have known more about pus than we do. They could look at pus and tell you what was going on; and at sputum, too. And if we were to find ourselves cut off from modern supplies, and treating patients, I wonder if we could do as well as the physicians who practiced only a few years ago.

—F.C.

ON INDEPENDENCE DAY

Button Gwinnett signed the Declaration of Independence, and he wrote his name so seldom that his signature was worth twenty thousand dollars when $20,000 was worth $20,000.

Now that the government, in its nearly infinite wisdom, has thrust paperwork on us by the ream, Button Gwinnett's signature, if he were a doctor today, would be worth very little, unless it appeared on a check, and even then it would not fetch much.

Nobody collects doctors' signatures.

—F.C.

THE BABY IS A PATIENT, TOO

I shall always believe that anesthesia is this country's greatest gift to an unappreciative world. It is evidence of our compassion and of our ingenuity and we gave it freely to all who would listen.

One of its earliest uses was the obtundation of pain in childbirth. But the physician who cares for a pregnant woman has two patients, not one.

Enormous pressures are exerted on the borning child as it leaves its uterine hideaway and traverses the birth canal, and it is likely that unborn and being-born babies can know pain; they have been said to cry before birth.

If pain in the delivery room is shared by mother and child, it is curious, then, that pain relief is provided for the mother and not for the child. This is almost entirely in the name of safety, since anesthetized babies are depressed babies, and do poorly. But it may be possible, *not now, but in the future,*

with *further inventiveness* and *newer techniques,* to deliver a baby, not depressed, and not hurting. I think it is likely that there are life-long effects resulting from our coming into this world in pain.

The duty of the obstetrician and the anesthetist is to deliver a healthy baby. This is usually called viable, which is a bad word, and one I can do without. But we may some day come to know that the baby feels pain in the act of birth, and we may see this as a problem that properly wants solving, and when we do, we may solve it, and deliver the baby without pain to mother or child, and without danger.

For the baby is not a nonentity; it is a living human being with all its rights.

And one of them is freedom from pain.

—F.C.

Evaluation of Five Drug Combination Chemotherapy in Management of Recurrent Carcinoma of Breast — J. M. Lee et al (Johns Hopkins Univ School of Medicine, Baltimore 21205). Surg Gynecol Obstet 138:77-80 (Jan) 1974.

Five drug combination therapy was evaluated in 32 patients. The five drugs used were prednisone, cyclophosphamide, fluorouracil, vincristine, and methotrexate. A complete or partial remission was obtained in 15 of the patients treated, and symptomatic relief was obtained in an additional seven patients. These results were obtained with little morbidity.

Enuresis: Analysis of Various Trerapeutic Approaches — S. Marshall et al (Univ of California School of Medicine, San Francisco 94122). Pediatrics 52:813-817 (Dec) 1973.

Three hundred patients with enuresis, 3 to 14 years of age, were treated by various techniques and the effectiveness of these techniques compared. When the child took active responsibility for seeking to change his behavior pattern and was supported by reinforcement from his family and physician ("responsibility-reinforcement" technique), the results were more successful than when the child was a passive participant in the therapy, as with instrumentation-surgery, medications, or conditioning devices. The responsibility-reinforcement technique is less disruptive than other therapeutic modalities from the physiological as well as the psychological standpoint. Therefore, after organic causes have been ruled out, the responsibility-reinforcement technique provides an optimal initial approach for the treatment of enuresis.

Massive Brain Hemorrhage: Review of 144 Cases and Examination of Their Causes — W. F. McCormick (Div of Neuropathology, Univ of Texas Medical Branch, Galveston 77550) and D. B. Rosenfield. Stroke 4: 946-954 (Nov-Dec) 1973.

A detailed clinicopathological study of the causes and locations of massive nontraumatic brain hemorrhage in 144 patients is reported. A cause of the hemorrhage, such as an aneurysm, angioma, arteritis, neoplasm, or a blood dyscrasia (leukemia, hemophilia) was proved in two thirds (95) of these patients. In 12 normotensive patients, no cause was found for the hemorrhage. Systemic hypertension, generally mild, defined as a preictal pressure of >140/90 or by excessive heart weight, was present in 58 of the 144 patients.

Liver Scans and Detection of Clinically Unsuspected Liver Metastases — R. J. Davies et al (D. M. Croft, Isotope Dept, St. Thomas' Hosp, London). Lancet 1:279-280 (Feb 23) 1974.

To determine the value of radioisotope liver imaging in the preoperative assessment of patients with treatable cancer, liver images were obtained in 46 patients with carcinoma of the large bowel who did not have hepatomegaly. At operation or necropsy, eight (17%) were proved to have hepatic secondaries, and liver scans detected seven of these. The techniques gave a correct answer in 44 patients, giving an overall accuracy of 95%.

The Breast Cancer Controversy

GEORGE CRILE, JR., M.D.*

A wise philosopher once said, "Ignorance ain't not knowing things. Ignorance is knowing so damn many things that ain't so." It seems to me that these remarks can be appropriately applied to the current controversy over the surgical treatment of operable breast cancer.

The proponents of radical mastectomy urge that this operation, with or without radiation, be used as the standard treatment for all patients with operable breast cancer. They do not do this because they are ignorant of the pathology and natural history of the disease. They do it because they know "so damn many things that ain't so." If we look at the history of breast cancer, it is easier to understand why so many erroneous concepts enshroud its surgical treatment.

The standard radical mastectomy was first done in 1867 by Sir Charles Moore, of London. Twenty-seven years later, Dr. William Halstead of Johns Hopkins, reported his first fifty cases and urged that this operation become the standard treatment of breast cancer. At the time, this seemed to be a good idea, for the tumors that Halsted described were, on the average, "the size of an orange" or larger and often the entire breast was involved and fixed to the muscles. In nearly a quarter of the cases, the cancers were ulcerating. All of the first 50 patients except the 2 who had no cancer, had extensive involvement of the axillary nodes, most of which were described as fixed or matted. Halsted was dealing with what we would call inoperable cancers.

Since radiation therapy was not available in the 1800's, Halsted's choice lay between a radical operation or living with a sloughing, malodorous tumor. This accounts for the fact that at the time of Halsted's report, although only 10 of the 48 patients with cancer had been followed for more than 2 years, and only 1 for 3 years, 57% of them had already died.[1] The incidence of local recurrence, moreover, was 31.9%.[2]

In the 1890's surgeons knew nothing of the cancer cells that circulate in the blood and permeate the lymphatics. Their conception of the spread of cancer was of a slow local invasion of lymphatics followed much later by systemic spread. They knew nothing of the role of the lymphocyte in the body's immunologic defense against cancer, or of the role that injury of tissue or that of blocking the flow of lymph or blood plays in trapping cancer cells and stimulating their growth. In short, they lived in a world of anatomy, in which they concluded that the biggest possible operation was the best. In the 1890's this seemed logical. Today, all is changed.

We now know that cancer of the breast is a systemic disease, in that by the time it is diagnosed its cells are widely distributed throughout the body. Whether these cells are destroyed by the host or grow into fatal metastases depends not on the size of the operation done but on the balance between the aggressiveness of the tumor and the defenses of the host. Of course, the primary tumor must be removed, and if regional nodes are involved sooner or later these must be removed or irradiated, but once the primary tumor is gone no one has ever shown that there was any urgency about removing nodes or that surgical removal had any advantage over radiation. For this reason an adequate local operation with simultaneous resection of nodes, if at the time of axillary exploration they seem to be involved, or by no treatment of nodes when they are not palpably involved, results in just as high a rate of survival as radical or ultra-radical mastectomy.

Proponents of the radical operation quote three or four remarkable series in which 10-year survival rates as high as 61% have been reported. They point to the 44% 10-year survival rate that my colleagues and

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I report, and claim that the difference is because we do chiefly modified radical mastectomy, with some simple and partial mastectomies instead of doing the standard radical. What they do not explain, however, is why the 10-year survival rates that they report are so much higher (18%), than those reported in the National Cancer Institute's 1972 book on "End Results in Cancer." The 10-year survival rate of the States of Massachusetts, Connecticut, California and of the six University Hospitals that cooperate in the Registry is 43%. Almost all of these patients were treated by radical mastectomy. The staging and the proportion of inoperable patients who lived 5 years, as well as the 10-year survival rate is almost identical to that of my colleagues and myself. Therefore, it seems to me that the 18% higher survival rate obtained in some of the series must be explained in some way other than by the type of operation employed. It must be the result of the stage of the disease in the patients selected for treatment.

If less than radical operations were to result in a higher death rate from cancer than can be obtained by radical ones, it would have to be through an increased incidence of local recurrence. A radical operation cannot cure a cancer that has already metastasized; all it can do is to control the local growth. But our rate of local recurrence is only 6%, which is lower than the 12% to 18% that is reported by most of the surgeons who do radical mastectomies. The reason for this is that we cut our skin flaps thick, preserving the supply of blood and the drainage of lymph, with the result that the cancer cells are not trapped and stimulated to growth by injury of the tissue.

Although we have not conducted prospective randomized studies comparing the results of partial mastectomy and total mastectomy, our retrospective, randomized matched-pair study between 42 patients treated by partial and 42 by total showed that at 10 years there was no difference in the proportion of patients who had died of cancer. They were matched for type of cancer, size of cancer and involvement of nodes. It is interesting, moreover, that more new cancers occurred in the contralateral breasts of the patients treated by partial mastectomy than in the affected breasts.

The reason that it is so important for the physicians to keep an open mind about the treatment of cancer of the breast, and to recognize that the morbidity of radical mastectomy is no longer necessary is that today women fear the treatment of breast cancer almost as much as the disease. I have asked all women who have delayed treatment why they did so, and almost always, when confidence is gained, they admit it was because of fear of radical mastectomy. Many of these women were nurses, paramedical workers or relatives of physicians. They did not delay through ignorance.

I believe that when the radical mastectomy is abolished and women realize that sometimes, if they report early, the major part of the breast can be saved, I think that when that day comes women will seek earlier diagnosis and a higher proportion of them will be cured.

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A Realistic Appraisal of the Case for Conservative Operation for Breast Cancer

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IN his recently published book entitled, "What Women Should Know About the Breast Cancer Controversy," Dr. Crile[1] asks, "Why then, when most European surgeons have abandoned radical surgery, do the majority of American surgeons persist in performing radical mastectomies? And how in the face of so many randomized studies conducted in England and Scandinavia, can American surgeons remain convinced that their patient's survival is improved by inflicting on them the disability and deformities of radical mastectomy?" He continues, pointing out that in 1969 A. P. M. Forrest reported that only 21% of British surgeons were performing radical mastectomies. He did not go on to say that 54% of British surgeons were performing either radical or modified radical mastectomy, and that the latter procedure has gained a large measure of acceptance by American surgeons for properly selected cases. Nor did he report that only 3% of the British surgeons polled favored local excision for cancer in the lateral segments of the breast, a procedure which Dr. Crile[2] contends is appropriate for 50% of patients with operable cancer. Nevertheless, his question should be answered.

In the past dozen years a number of articles have been published by Dr. Crile[1-5] condemning the use of standard radical mastectomy. During this period there has been a trend in his own practice toward the election of increasingly more conservative procedures.

A mass of statistical data has been offered in support of this trend which, except for his own, has been drawn almost wholly from outside the United States. On casual or superficial reading much of the data in these reports appears plausible, but when these statistics are examined with anything approaching analytic detachment and objectivity, the sources most commonly quoted reveal extensive and easily demonstrated bias in the form of favorable case selection; and often, in addition, conclusions totally unwarranted by the data. The bias is often flagrant, but at times subtle, and apparent only upon careful analysis, and frequently indicated more by the absence of vital prognostic data which, though obviously available, the authors have chosen not to reveal.

It is beyond the scope of this paper to consider in detail all of the pertinent literature, but some of the most commonly quoted sources will be discussed.

THE SMITH AND MEYER PAPER AND THE SHIMKIN REVIEW

These reports are among the most commonly cited as evidence of the effectiveness of simple mastectomy in the treatment of operable cancer of the breast.

The original paper by Smith and Meyer[6] compared the results of treatment by simple mastectomy or local excision with radical mastectomy in Rockford, Illinois for the years 1924-1952; and a subsequent review by Shimkin,[7] et al, of the experience for the years 1924-1954 resulted in the same conclusion: "That "neither the 5 nor 10 year-survival rates were affected by the type of operation, the duration of the tumor or the skill of the surgeon." This aroused the following comment from Ackland[8] under the title of "Statistically Worthless Figures." "A further cause of confusion is the fact that so many reports contain figures that are statistically worthless either because of the small number of cases reported or ab-

sence of random selection, or because the groups under consideration differ in more than one essential. In one such review by Smith and Meyer (1959) of 11 cases of lump excision, 84 cases of simple mastectomy and 324 cases of radical mastectomy, the fantastic conclusion was reached that survival rates were not affected by the type of operation, duration of the disease, or the skill of the surgeon."

These reports have been so widely quoted that we believe that some analysis of the real significance of these data is required.

First of all, Smith and Meyers compared the results of treatment of 13 "experienced" surgeons, and 56 occasional operators and found no significant difference in the end results. The 13 "experienced" surgeons did 200 operations in 28 years. This is a rate of 7.1 operations per year or 0.55 operations per surgeon per year; and for radical operations, 0.5 per surgeon per year.

The 56 occasional operators did 232 operations in 28 years or an average of 8.3 per year and .15 cases per surgeon per year, and for radical operations, .094 per surgeon per year.

The quality of the surgery that could be expected under these circumstances is attested by the fact, as reported in the Shimkin Review, that of 49 patients treated by radical mastectomy in the first of the 3 time periods considered (pre-war), 22.5% died within 1 year, two postoperatively; a higher mortality rate than that observed by Daland[9] for patients having no treatment at all! Only 53 of the so-called simple operations were in fact true simple mastectomies. This gives a rate of 2 true simple mastectomies per year. Of 103 so-called simple mastectomies, 39% had proven regional metastases. Of 345 radical and modified radical mastectomies, 56% had proven metastases.

In the third period (post-war) the quality of some of the surgery is reflected by the fact that the mortality for simple mastectomy was 10%. And in this period the 10 year survival rate for simple mastectomy was 8% versus 42% for radical mastectomy, and some of these simple mastectomies may have had axillary dissections.

It seems to us that it is time to recognize that this much quoted experience is totally without merit and has no relevance to the problem of the choice of operation as it confronts us today.

THE KAAE AND JOHANSEN PAPERS[10, 11]

In a previous paper on this subject we have discussed in detail the flaws in this so-called randomized clinical trial comparing patients treated by simple mastectomy followed by postoperative irradiation by the McWhirter method versus extended radical mastectomy according to the Dahl-Iversen technique, which included supraclavicular and parasternal node dissection. This report has been so widely cited as evidence that the results of simple mastectomy and irradiation are equal to those obtained after radical mastectomy that it will again be summarized here briefly.

In this trial, the patients were originally selected by a random method and 331 were designated for treatment by the McWhirter method and 335 by extended radical mastectomy. However, all semblance of randomization was nullified by the subtraction of a large number of patients as inoperable or for a variety of other reasons, leaving only 425 of the original 666. Of these, 219 were available for treatment by the McWhirter method and 206 for treatment by extended radical mastectomy. But, an additional 25 patients in the group designated for treatment by extended radical mastectomy did not receive the planned treatment because at operation 15 were found to be inoperable, 8 were in unsuitable condition for the radical procedure, and two refused the planned procedure and underwent simple mastectomy. Yet these 25 cases — 12% of the total are used in the comparison of end results as part of the group supposedly treated by extended radical mastectomy. Only 181 patients actually received the planned treatment.

Moreover, there is good reason for the belief that the piecemeal dissection of the parasternal lymph nodes by the Dahl-Iversen

method may well have been a factor in spreading the disease. Despite these flaws in the conduct of the trial the 10 year survival rate for the patients treated by extended radical mastectomy was 50% versus 45% for the McWhirter group. In addition, as Urban[12] has pointed out, although only 35% of the radically treated patients had axillary metastases, 13% showed recurrent disease in the axilla in 5 years. This can hardly be explained in any way other than by an assumption of totally inadequate axillary dissection.

But the most telling proof of the ineffectiveness of the McWhirter method by comparison with radical or modified radical mastectomy is the extremely poor showing of the Kaae and Johansen results when submitted in participation in the Cooperative International Study undertaken by Haagensen[13] and others.

Table I* right shows that despite the massive advantage resulting from the fact that 81% of their cases were in Columbia Stage A compared with 54%, 63%, 54% and 48% of the cases of Butcher, Haagensen and Cooley, and Handley and Thackray and Williams and Stone, their 10 year survival figures were exceeded by substantial margins by all of the others for Stage A cases and for cases in Columbia Stage A, B and C by all except the Butcher series whose results were virtually identical, 44% versus 45%. However, the Butcher series contained only 54% of Stage A cases versus 81% in the Kaae and Johansen series. The Table also shows the even poorer survival figure for the Miller simple mastectomy series despite the fact that this also contained a higher percentage of Stage A cases than any of the groups treated by radical or modified radical mastectomy.

THE EDINBURGH EXPERIENCE

Sir John Bruce[2] has reported the experience of the Royal Infirmary, Edinburgh, with the McWhirter treatment for the years 1946 to December 1957. Three hundred thirty-five patients in Stage I and II were available for study. The 10 year survival rate was 40%.

*Modified from Table 18 from this study by elimination of Stage D cases in all series and of series reporting on extended radical mastectomy.

Table I

RESULTS OF TREATMENT OF MAMMARY CANCER 10-YEAR SURVIVAL — COLUMBIA CLINICAL CLASSIFICATION

	SIMPLE MASTECTOMY		RADICAL MASTECTOMY OR MODIFIED RADICAL MASTECTOMY (AXILLA DISSECTED)							
	Miller(14)		Kaae & Johansen(15) McWhirter Method		Butcher(16) Rad. Mastectomy		Haagensen & Cooley(17) Rad. Mastectomy		Handley & Thackray(18) Mod. Rad. Mast. (Patey)		Williams & Stone(19) Mod. Rad. Mast. & Ax. Dis.	
	No. of Cases	% 10-Yr. Survival	No. of Cases	% 10-Yr. Survival	No. of Cases	% 10-Yr. Survival	No. of Cases	% 10-Yr. Survival	No. of Cases	% 10-Yr. Survival	No. of Cases	% 10-Yr. Survival
Cases Stage A	70%		81%		54%		63%		54%		48%	
Stage A	115	40%	159	50%	216	56%	344	70%	77	61%	68	59%
Stages A, B, C	167	35%	196	45%	399	44%	545	55%	143	50%	141	49%

Since 1964 a randomized clinical trial has been under way comparing the results in operable patients between the ages 35-70 treated by simple mastectomy followed by irradiation by the McWhirter method and standard radical mastectomy. Prophylactic ovariectomy was done on all patients under age 60.

Within a 5 year period 41 of 191 (21.4%) of the "simple" group and 31 of 204 or 14.4% of the radical mastectomy group are dead.

Five year survival figures were available for about 100 cases in each group and were 76% for the radical group and 66% for the simple.

The percentage mortality within each treatment group plotted according to the year of entry and the year of follow-up showed an increase in mortality among the women treated by simple mastectomy and radiotherapy for each year.

All of these evidences of the superiority of the radical operation are regarded as "not statistically significant."

Another factor which may well be of significance is the quality of the surgery, for Bruce says that many of the participants in the trial had to learn or relearn the technique of the radical operation which had been rarely practiced in Edinburgh for 25 years.

Table II shows a comparison of the 10 year survival figures for the 1946-1957 series with others reported from other centers in Great Britain.

THE CAMBRIDGE TRIAL

Dr. Crile[4] refers to this trial conducted by Brinkley, E., and Haybittle, J. L.,[23, 24] as a comparative study of the results following treatment by *simple* mastectomy and radical mastectomy, and Fisher[25] describes it as "one of the most important studies to be reported relative to the worth of *simple mastectomy.*" In each group the surgical procedure was followed by postoperative irradiation. But the protocol for this trial provided that in the simplified procedure the surgeon had the option of removing "accessible axillary glands" and this option was exercised in 79% of the cases.

Our interpretation of this, and we believe it would be that of most surgeons accustomed to doing axillary dissection, is that it would result in an operation, if not identical with, at least far closer in scope to Crile's description of his concept of a radical operation than to "simple mastectomy." Moreover, a second condition for entry into the trial was that the surgeon was prepared for his patient to have either of the two operations and to have postoperative x-ray therapy. The authors state that "this meant that not all Stage II cases seen by the surgeons were entered for the trial." Obviously this then, was not a true randomized trial.

There are other serious flaws in this study which seem to be overlooked by advocates of simple surgery who quote these results in support of their position. First, although this was supposedly a randomized trial, in the first two years nearly twice as many patients were treated by the simpler method than by the radical operation. The conduct of the trial was abandoned in the middle of the seventh year, apparently from lack of interest. In the last full year of the trial only 7 patients were treated by radical mastectomy; a rate of 1 per year for each of the participating surgeons, and in the previous year only 12 were treated. For a metropolitan area serving several hundred thousand persons, this would hardly seem to be a representative sample of their total experience. Fifty-six percent of the radical mastectomy cases had proven positive axillary nodes versus only 41% of the simple group who had axillary specimens. The radical mastectomy series contained nearly twice as many patients with inner quadrant tumors.

Table II

Author	Method	% 10 Year Survival
Bruce[20]	Simple + Irradiation (McWhirter Method)	40%
Gordon-Taylor[21]	Radical Mastectomy	50%
Lee & Lambley[22]	Radical Mastectomy	45%*
Handley & Thackray	Modified Radical (Patey)	50%
Williams & Stone[19]	Modified Radical	49%

*—Free of disease

No useful information is offered regarding the size of the tumors in the two groups. The only information supplied is that the mean size of the tumors measured in *square* centimeters was 9.4 for the simple group and 10.3 for the radical. This is impossible to translate into meaningful terms. What one would like to know is the relative percentage of tumors 2.5 cm. or less in each group. Moreover, there is a substantial body of evidence that suggests that routine postoperative irradiation after radical mastectomy may be harmful. And finally, although the 10 year actuarial survival figures show virtually no difference for the two groups, this calculation cannot have been based on more than 47 radical mastectomy cases followed for the full 10 years. In fact, the authors state the differences between the two groups are small and not at all significant statistically.

THE PETERS PAPERS

Of these studies, Crile[1] says this report of Dr. Peters[26] of Toronto shows that the rate of survival following partial mastectomy and radiation is at least equal to that following radical mastectomy. And Fisher[24] says, "she has provided information to support her conclusion that wedge resection and irradiation were as effective as any other treatment plan in Stages I and II breast cancer provided that each measure is technically acceptable."

In a previous publication[27] we have discussed the report referred to in detail. Peters has reported on a series of cases observed at the Ontario Institute, Toronto, of Stage I and II patients who had an excisional biopsy prior to or at the same time as the major treatment between the years 1935 and 1960. There were 825 patients, and 200 received radio-therapy as the first or major treatment following the biopsy. These were divided into four groups. Groups A and B received radical irradiation at some interval following the excisional biopsy and of these, Group B were treated by mastectomy at a later date.

In Group C, radical surgery was the first major treatment at an interval of more than one day following the excisional biopsy and postoperative irradiation. In Group D, a quick-section excisional biopsy was performed immediately preceding radical surgery.

The 5 and 10 year survival figures are as follows:

Table III

Group	Number of Cases	5 years	% 5 years	10 Years	% 10 Years
A	124	94	76	62	48
B	76	54	71	**	52
C	308	233	76	162	50
D	344	247	72	399	44

**—not given

The following things are wrong with this study and invalidate Peter's conclusions:

1. Although the cases in this study were classified and all were in Stage I or II, no information is offered regarding the distribution of the Stage I and II cases in the various groups.

2. No information is supplied regarding the extremely important prognostic factor of tumor size in various groups.

3. Every surgeon with any considerable experience with breast cancer is well aware of the fact that when the sequence of events of local excision of a tumor is carried out, followed by delay in the decision regarding definitive treatment, the reason, with rare exceptions, is that the tumor was regarded preoperatively as benign and only local removal was contemplated and the patient was not apprised of the possibility of mastectomy. In short, this is a highly selected, extremely favorable group of cases and comparison with a group treated by radical mastectomy after immediate frozen section is completely invalid.

4. All the force of logic would imply that even those who were treated by radical mastectomy following a period of delay would have been selected for this treatment because they were considered less favorable as a result of the information gained from the local excision than those for whom it was considered reasonable to add only irradiation.

5. The patients treated by initial radical mastectomy were chosen from an earlier

time period, some undoubtedly dating back to 1935 when patients on average were in a more advanced stage of the disease than those observed in a later time period. This observation is apparent from the fact that 98% of the patients in this group were eligible for the 10 year follow-up versus only 50 to 52% of the other groups.

Of the 76 patients in Group B who had radical mastectomy following local excision and irradiation, 8 had residual disease in the breast and 13 had residual carcinoma in axillary nodes. All but 3 died of their disease before 10 years, giving a survival rate of 14%.

In a more recent article,[28] Peters has presented an analysis of 8481 patients with breast cancer observed between 1938 and 1963 inclusively. The following points are noteworthy.

1. The operability rate was inordinately low, 41%.

2. The author states "a large proportion of Stage I patients treated by radical mastectomy are not referred to an institute of radio-therapy." Thus, in the subsequent comparison of survival periods for the various types of treatment the radical mastectomy series suffers from the failure to include in the calculation a large proportion of the most favorable group, the Stage I cases, completely invalidating the comparison with the results of local excision.

3. There is only an obscure reference to the distribution of the tumors by stage in the various treatment groups in the form of a "Stage Distribution Ratio." This does not provide any specific information which would permit critical analysis.

4. No information beyond the staging is offered regarding the vitality important prognostic factor of tumor size, and in view of Point #3, the staging is of no value in evaluating this factor.

We find it difficult to resist the conclusion that in the presentation of this data there has been a studied effort to withhold the explicit information which would allow a judicial appraisal of the authors conclusion that "within each stage and age groups, a significant difference in survival rates according to method of treatment could not be demonstrated."

THE MUSTAKALLIO PAPERS

Among the most commonly quoted reports cited by supporters of conservative surgery are those of Mustakallio from the Radiotherapy Clinic at the University Hospital in Helsinki, Finland.

In 1954, Mustakallio[29] reported the cases of 107 patients treated by local or wedge resection followed by irradiation therapy with a 5 year survival rate of 84% and in a very small number of cases followed for 10 years, 13 of 18 or 72%. It is not always acknowledged by those who quote these figures that they reflect an extreme degree of favorable case selection. Mustakallio states that, "the method should be used *only* when examination of the patient reveals that the cancer has not spread beyond the mammary gland and the primary tumor could be easily extirpated and that it should not be used when the tumor is clinically ill defined." These stipulations insure a selection of small and very favorable tumors, actually a highly selected group within an already selected group, i.e., Stage I.

In his most recent report in 1972, Mustakallio[30] has reviewed his experience for the previous 25 years. His conclusion was that "the 5 year survival rates have throughout been no poorer than after radical surgery and our opinion as to the superiority has been consistently reinforced." And he goes on to say, "this notwithstanding fairly few surgeons in Finland employ this method." Analysis of Mustakallio's end results provides a very good reason for this. Some time after Mustakallio's original report, the criteria for the application of the method have been expanded to include all Stage I cases. His 10 year relative survival rate by an actuarial method for all 418 cases followed for 10 years is 75% and the observed rate, 61%. For the more recent cases numbering 284 with follow-up less than 10 years, (9 years), the relative survival rate is not given, but since these patients are drawn from the same population there is no reason to believe that it would not be in proportion to the difference between the rela-

tive and observed rates for the other series. Projected for 10 years, this would be about 45%, a conspicuously low figure for Stage I cancer; how poor it is may be judged from the comparison with 10 year survival figures from other centers.

Table IV

Author	Stage	Method of Treatment	% Survival at 10 Years
Mustakallio[30]	I	Local excision & irradiation	45%
Dunphy[31]	I	Radical Mastectomy	71%
Gordon-Taylor[21]	I	Radical Mastectomy	84%
*Anglem & Leber[27]	A	Radical Mastectomy	64%
Butcher[16]	A	Radical Mastectomy	56%
Haagensen & Cooley[17]	A	Radical Mastectomy	70%
Handley & Thackray[18]	A	Patey Modified Radical	61%
Williams & Stone[19]	A	Modified Radical	59%

*—For patients treated between 1949 and 1959.

THE PORRITT PAPER

Fisher and Crile have both cited Porritt's[32] report showing superior survival rates for patients treated by local excision and x-ray therapy. In this report by Sir Arthur Porritt, however, the author states that it presents all the fallacies of random selection without adequate controls. Porritt has reported 45% 10 year survivors for the local excision group versus only 34% for the radical mastectomy group. These results are almost identical with those reported by Crile[33] in 1968, 48% and 34% respectively, in a comparison of simple versus radical mastectomy. As we have previously pointed out,[34] with respect to Dr. Crile's reports, it is obvious that in any treatment center where patients are treated by two different methods, one conservative and one more radical, favorable case selection can influence the results in one group at the expense of the other. In such a circumstance the true effectiveness of the treatment policy must be based on the total salvage in all cases treated by both methods. Porritt's total salvage is 38.7% and Crile's,[32] 40%. Both are conspicuously low when compared with results reported from other centers where radical or modified radical mastectomy has been the method of treatment, as shown in Table 5.

THE CRILE PAPERS

Dr. Crile[35, 36] states that in 1955 he decided to use simple mastectomy, usually without irradiation therapy as the standard treatment of most patients with cancer of the breast. One reason for abandoning radical mastectomy was his belief that removing uninvolved regional nodes may diminish the patients immunologic resistance to the spread of cancer. More recently, Crile has been advocating local excision and it is suggested that this procedure is appropriate for 50% of patients with operable tumors.

Since Dr. Crile's influence in this area is considerable and since these doctrines are being pursued with great zeal and pertinacity, it seems imperative that the unsub-

Table V

COMPARISON OF PORRITT 10 YEAR SURVIVALS, AND OTHERS

Author	Porritt(33)	Gordon-Taylor(21)	Lee & Lambley(22)	Williams & Stone(19)	Handley & Thackray(18)
Method of Treatment	Local excision and x-ray	Radical Mastectomy	Radical Mastectomy	Mod. Radical Mastectomy	Mod. Radical Mastectomy (Patey)
Stage of Disease	Early & late	I & II	A, B, C*	A, B, C*	A, B, C*
10 Year Survivors %	38.7%	50%	45% (Free of Disease)	49%	50%

*—Columbia Classification

stantial and illusory character of his supporting statistics be brought out.

In 1968 Dr. Crile[33] published a paper making some interesting comparisons between patients treated by simple mastectomy and those treated by radical mastectomy and purporting to show superiority for the former. One of these, a comparison of results of simple mastectomy with those of radical mastectomy in patients with operative Stage I cancers and occult cancer in nodes is an example of portrayal of failure as a success. Forty-seven patients who had no palpable involvement of axillary nodes at the time of mastectomy and axillary exploration (operative Stage I), subsequently were proved to have nodes. Twenty-two of these were treated by radical mastectomy and the pathologist found unsuspected cancer in nodes. The remaining 25 were treated by simple mastectomy without irradiation. In from 1 to 84 months (averaging 24 months), cancer appeared in the axillary nodes of these patients and was then treated in 22 cases by axillary dissection and in 3 by cobalt teletherapy.

Crile points out that in the patients having delayed axillary dissection the proportion of patients having *minimal* involvement of nodes at the time of delayed axillary dissection was higher than in those whose nodes were removed initially by radical mastectomy. After simple mastectomy, 40% of the patients had only one node involved as compared with only 27% of the radically treated ones. He emphasizes the point that extensive involvement of nodes did not seem to be more common after simple mastectomy and delayed axillary dissection. The survival rate for both groups was the same, 68%. The implication seems clear that he somehow has arrived at the belief that these observations indicate an advantage in favor of simple mastectomy. Obviously, the only possible logical explanation of these facts is that there was heavier involvement of the axillary nodes in the radically treated cases to begin with. Although Crile states that the average number of nodes in the two groups were similar, a previous and more informative report[36] on this same study shows that this was not the case and that the radically treated cases had far heavier involvement of the nodes than the simple mastectomy group, as indicated in the figures from his 1961 paper.[36]

Table VI

RADICAL MASTECTOMY SERIES Number of Nodes	SIMPLE MASTECTOMY SERIES Number of Nodes
1	3
2	1
12	Treatment with cobalt
6	3
1	1
5	1
16	12
16	Treatment with cobalt
2	1
3	1
1	
10	
1	
—	—
76	23

Of the radically treated cases the average number of nodes per case was 6 and for the simple mastectomy group, 3.

Only one patient in the simple mastectomy group had more than 3 nodes involved versus 6 for the radical series. Sixty percent of the patients in the simple group had only a single node involved versus 30% of the radically treated group. In the simple mastectomy series there was only one patient with 10 or more involved nodes in contrast with 4 in the radical series.

The correct conclusion to be drawn from this comparison is that despite far heavier involvement of the axillary lymph nodes in the radical mastectomy series, massive by comparison with that in the simple mastectomy group, the survival rate nevertheless was equally good.

In the various articles published by Dr. Crile a mass of statistical data has been offered in support of the thesis that equally good, and at times superior results are obtainable by conservative operations than by radical mastectomy, but when the statistics offered in support of this proposition are carefully examined it is abundantly clear that far from furnishing support for a conservative policy they provide a very

forceful argument against it, and in favor of radical treatment. The statistics offered in support of the supposed superior results for the simplified treatment are clearly dependent on extensive and easily demonstrated bias in favorable case selection.

In his 1961 paper,[36] Crile has reported a comparison of the results of simple mastectomy versus the radical operation for the years 1955 through 1959. Ninety percent of the simple series were Stage I as opposed to only 71% of the radically treated group. In a comparative study published in 1964,[5] 84% of the simple mastectomy cases had Stage I disease as compared to only 61% of the radically treated patients.

In a recent paper[37] comparing 133 patients treated by simple mastectomy and 93 by his radical operation, only 57% of the radically treated patients had Stage I disease versus 76% of the simple mastectomy group. In still another paper,[33] a footnote to one of his tables reveals that a staggering 96% of the most favorable cases with extremely small tumors (less than 1.5 cm.) were allocated for treatment by simple mastectomy versus a mere 4% by radical operation.

This great preponderance of Stage I cases in the groups treated by simple mastectomy is not the full extent of the bias in selection. In the second mentioned paper, for example, 25% of the tumors in the simple mastectomy group were less than 2 cm. in diameter, as opposed to only 7.5% of the radically treated cases.

In a comparative study carried out in 1968,[33] 52% of the patients were treated by simple mastectomy and the overall 10 year survival rate for all cases treated was 40%. Four years later in 1972[37] when the percentage of cases treated by simple mastectomy had risen to 60%, his survival rate declined to 36.5%. In contrast to these figures, survival rates from 50 to 60% have been reported from many treatment centers both here and abroad in which radical or modified radical mastectomy has been the primary method of treatment.

It is especially noteworthy that the increasing application of simplified treatment resulted in a deterioration of the survival rate for all patients treated.

It is also of interest that with further simplification of treatment by the use of local excision and further refinement of the criteria for selection the survival rate at 10 years has declined further. In a paper published in March, 1972, Crile[38] reported a series of 49 patients treated by local excision. These were highly selected, limited to the periphery of the breast and averaged 2.1 cm. in diameter. Seventy-six percent were in Stage I and for these the 10 year survival rate was 42%, a conspicuously poor survival rate for Stage I cancer.

In a still later paper[39] he reported his experience in a series of 53 patients treated by local excision in which similarly highly selected patients with tumors averaging only 2 cm. in diameter, yielded a survival rate at 10 years of a meager 34%, a figure that is exceeded by 15 to 25% in reports from many centers in which radical or modified radical mastectomy has been the surgical procedure in totally unselected cases in all operable stages.

But the strongest evidence of the poor performance record of conservative procedures is its conspicuous failure in those patients with more than minimal disease. In Dr. Crile's series of 226 patients,[37] he reports only a single patient with more than four involved nodes who is alive and free of disease at 10 years. In our series of an identical number of patients treated by radical mastectomy we have 10 or 19% of 53 patients alive and free of disease, and Haagensen[40] has reported a 22% survival rate for Stage A patients with 4 to 7 involved nodes and 18% for those with more than 8 involved nodes and 35% and 9% respectively for Stage B patients.

Crile[37] reports further that of 226 patients with tumors more than 3.5 cm. in diameter, and clinically palpable involvement of nodes, only 3 were free of cancer 10 years later. In our series of 226 patients treated by radical mastectomy, we have 8 cases with tumors 4 cm. or larger who had clinically palpable involvement of nodes, all of which were confirmed microscopically, and 3

others doubtful clinically, but positive microscopically, and tumors 4 cm. or larger, who survived 10 years or longer *without disease.*

Discussion and Conclusions

Advocates of limited surgical procedures, who hold that standard radical mastectomy is an archiac and obsolete procedure are prone to depict surgeons who differ from this view as wedded to an inflexible dogma, unrelenting in their insistence that any and all patients with breast cancer should be treated by standard radical mastectomy.

If there are any such, they are rare indeed. The fundamental position which we hold has been well stated by Urban,[41] that the scope of the primary operative procedure should be correlated with the extent of the clinical pathologic setting of disease in each individual patient with the aim of removing *all* disease present while interfering least with appearance and function.

Two factors of paramount importance which limit the choice of treatment are the very high incidence of multicentric foci of cancer in the breast as shown by Qualheim and Gall,[42] and Gallagher and Martin,[43] and the fact that even in the favorable category of Stage A by the Columbia Classification, 30% of patients will have involvement of the axillary lymph nodes. In fact, Barker[44] and associates have found 25% node involvement in a small series of occult carcinomas found by mammography.

On the other hand, Egan[45] has found that when carcinomas are identified by calcifications alone in the absence of palpable tumor and of demonstrable x-ray mass, that nearly 100% had normal axillary nodes. For this group and for non-invasive intraductal carcinoma any procedure more extensive than total mastectomy would be difficult to justify. For occult carcinomas with demonstrable x-ray mass, and for some small low-grade type tumors with limited potential for node invasion, we consider the modified radical operation the one of choice. We consider standard radical mastectomy obligatory for all Stage 2 lesions and for a large percentage of Stage 1 tumors, excepting only small superficially situated tumors, especially when the factors of age or concomitant serious medical disease are considerations. For these we consider the modified radical operation acceptable, although we prefer the Patey procedure to the more limited version of the modified radical.

Careful scrutiny of the writings of some of the most commonly quoted sources in support of conservative treatment of operable cancer of the breast reveals extensive and obvious bias in case selection which invalidates the claim for their effectiveness. Of even greater significance is the fact that despite the widespread bias in favorable case selection the survival figures reported still fall short of those reported from many treatment centers both here and abroad where radical or modified radical operations have been the prime method of treatment employed.

The least that the unfortunate victim of breast cancer has a right to expect from her surgeon is that the procedure which he elects will remove all of the accessible disease at the initial operation.

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Cancer of the Breast – Some Observations On its Present Day Management

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OUR experience with cancer of the breast covers a period of almost 40 years in which we have seen approximately 500 consecutive patients with this disease. Only four in the entire series have been lost to followup. Approximately one half of this series is now deceased.

Twenty-five percent of all patients seen initially are still classified as advanced by our own criteria, which means that the primary lesion is over three centimeters in diameter, there are four or more involved axillary nodes, there is definite skin involvement, or finally, there is evidence of distant metastasis.

In our overall series of cases, lymph nodes have been involved in 50.9%. If we consider those patients classified as early lesions with a mass under one centimeter and with no palpable nodes, we still find positive nodes on axillary dissection in from 25 percent to 30 percent of the cases.

Because of this figure and since the primary concept of surgical treatment of cancer requires that all tumor and its extension be removed if possible, we still believe that axillary nodes should be removed at the time of the primary operation. If the surgeon believes that he can do an adequate axillary dissection preserving the pectoral muscles, we would have no dispute if this type of operation be employed.

It is difficult for us to believe that if one leaves known cancer in axillary nodes in one out of three patients, as may occur with a simple mastectomy or lumpectomy, that this is good surgical practice. The concept that cancer resistance is increased by leaving involved axillary nodes is certainly not proven at this time.

That the overall results have not dramatically improved with radical mastectomy since originally introduced by Halsted, does not necessarily negate the operation, since the results before 1898 were dismal. It may clearly establish that radical mastectomy is a good operation in a disease in which the primary contest is between tumor virulence and body resistance.

Our figures show that of those individuals who develop cancer of the breast, seventy percent will die of their breast malignancy, twenty percent will succumb from cardiovascular disease and the remaining ten percent will develop a second, totally independent malignancy of a different nature which will be fatal.

Breast Cancer

ROBERT O. GARLINGHOUSE, M.D.

THE argument for more conservative treatment of cancer of the breast has been taken to the lay news media, with what I fear will be disastrous results. I do not believe that a television program is the place to discuss a difference in opinions on such a serious subject.

It is reasonable to assume, when we use a less radical approach to cure a potentially fatal disease, that we will have more deaths because of the inadequate treatment. I believe that the majority of surgeons who are experienced in treating cancer of the breast feel that lumpectomy, quadrectomy, modified radical, simple mastectomy, and any other inadequate operation will give the radiotherapist and the chemotherapist more patients to attempt alleviation of their suffering following the recurrence or metastasis of a cancer that could have been cured by proper radical surgery.

I have a book of statistical data on cancer of the breast, mostly worthless, because no two series use the same methods of compiling their cases. It is claimed that results are as good or better with less radical treatment, but there is a great discrepancy in the way the statistics were compiled. On the other hand, it has been stated that one surgeon alone has during his lifetime saved the lives of some 70 women who would not have been saved with inadequate surgery.

Do you want them dead with both breasts or alive with one breast?

Carcinoma of the Breast: How I View This Controversy

CLAUDE H. ORGAN*

STATISTICS from the American Cancer Society reveal that one of every fifteen women in the United States will be affected by carcinoma of the breast at some point in their lives and, therefore, this lesion continues to be a leading cause of cancer death in the American female. Since the McWhirter report (1948), there has been an increased worldwide concern regarding the appropriate treatment for carcinoma of the breast, resulting in an agonizing reappraisal of radical mastectomy and a consideration of alternate modalities of therapy.

Emerging from this extended investigation has evolved the following terms: (1) extended radical or supraradical mastectomy, (2) radical (Halsted) mastectomy, (3) modified radical mastectomy, (4) simple (total) mastectomy, and (5) limited procedures, i.e., lumpectomy, local excision, partial mastectomy, and tylectomy. Despite repeated dogmatic expressions from many quarters, there is as yet insufficient and credible data to outright condemn or support any single surgical procedure over the other.

Dr. Crile has performed a distinct service to American medicine in calling for "a series of carefully planned, randomized trials to define the least deforming and disabling treatment that will still give a satisfactory cure rate."

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It is important for physicians and the concerned laymen alike to appreciate the detailed investigative studies previously undertaken and reported. Listed below is a partial list of the comprehensive clinical studies on carcinoma of the breast of recent vintage that one should be familiar with to fully understand the true nature of this controversy:

(1) *Clinical Trials Concerning Surgical Management*

Copenhagen Trial (1957)
Guy's Trial (London) (1971)
Cambridge Trial (1955)
Kings Cambridge Trial (1972)
NSABP Protocol #4 (1972)
S. E. Scotland Trial
Cardiff Trial
West of Scotland Trial

(2) *Clinical Trials Concerning Postoperative Irradiation*

Manchester Radiation Trial (1955)
Stockholm Trial
NSABP Protocol #2 (1968)

(3) *Clinical Trials Concerning Prophylactic Castration*

Norwegian Castration Trial (1963)
NSABP Protocol #3 (1968)
Manchester-Ovarian Irradiation Trial (1955)
Toronto-London Castration Trial (1967)

(4) *Clinical Trials Concerning Adjunctive Chemotherapy and Hormonal Therapy*

Scandinavian Adjunctive Chemotherapy Trial
Toronto-London Androgen Therapy Trial
NSABP Protocol #1
Hammersmith-London Trial

As an outgrowth of this spirited controversy, several questions have emerged: (1) Is there sufficient information available to totally support or reject one surgical procedure over another? (2) Does a partial procedure leave behind axillary lymph nodes that are involved and is this helpful or harmful? (3) Is radiation therapy as effective a method of managing the involved axillary nodes as surgical excision? (4) Is this decision one which we should give the patient optional methods of treatment from which she should make her choice of therapy?

The technical factors surrounding such decisions, of course, are complex enough for the physician and are almost prohibitive from the standpoint of the layman fully understanding. Therefore, it is an abdication of our professional responsibility to transfer such a decision to an unsuspecting layman.

The current protocol for the evaluation of radical and total mastectomy with and without radiation in the primary treatment of cancer of the female breast currently being conducted and under the supervision of Dr. Bernard Fisher of Pittsburgh, Pennsylvania is, in my opinion, a valid study. It is a prospective, randomized clinical trial aimed at comparing two or more methods of treatment on similarly composed groups of patients and will be another very important step in delineating some of the factors that are currently operative in this particular controversy. Further, the 1973 statement of the American Cancer Society on the surgical treatment of breast cancer approved by the Board of Directors seems to be sensible and mature, and sets the stage for continuing progress in this area.

American Cancer Society Policy Statement On Surgical Treatment of Breast Cancer

BREAST cancer will affect one of every 15 women in the United States at some time during their lives and it remains the leading cause of cancer deaths in women.

A current controversy over the surgical treatment of breast cancer has tended to divert attention from the importance of early diagnosis through breast self-examination, periodic physical examination of the breasts by physicians aided by newer diagnostic advances.

Pending clear proof that equally good results can be achieved by limited procedures less than mastectomy, the American Cancer Society believes that the public should not be misled into accepting less proven methods.

The American Cancer Society has dedicated itself to promoting the control of breast cancer. The immediate major effort of such control has been in the field of early diagnosis. The selection of this special area of activity was made because the proven methods of therapy are highly effective (85-90 percent survivals at five years) when the diagnosis is made at an early stage and treatment is prompt. There is now reason for concern by the Society that some of the benefits of early diagnosis are being lost by inadequate and unproven methods of treatment.

Even when breast cancer is found early at least 20 percent of the cancers have already spread to adjacent lymph nodes. At present, there is no completely satisfactory method of identifying those tumors which have already undergone limited extension, and those which have spread beyond the confines of customary treatment. While studies continue in many disciplines on these exceedingly important questions, we must understand the nature and description of the various methods of treatment of breast cancer which apply to the tumor itself.

1. *Extended Radical Mastectomy or Supra-radical Mastectomy* — surgical removal of the internal mammary chain of lymph nodes, the entire involved breast, the underlying chest muscles and the lymph nodes in the axilla (armpit).

2. *Halsted Radical Mastectomy* — surgical en bloc removal of the entire involved breast, the underlying chest muscles and the lymph nodes in the axilla.

3. *Modified Radical Mastectomy* — surgical removal of the entire involved breast and many lymph nodes in the axilla. The underlying chest muscles are removed in part or are left in place after removal of the nodes in the axilla.

4. *Simple Mastectomy (more recently called Total Mastectomy)* — surgical removal of the entire involved breast. The underlying chest muscles and lymph nodes in the axilla are not removed.

Note: All of the above procedures remove the involved breast completely.

5. *Limited Procedures* — have received a variety of names including lumpectomy, local excision, partial mastectomy, tylectomy (comparable to lumpectomy). In each instance the tumor is surgically removed with a varying amount of surrounding tissue.

Historical Data

For many years surgeons have preferred the Halsted radical mastectomy as the operation of choice for most cancers of the breast. More recently, some surgeons have preferred the modified radical mastectomy for early cancers, or a simple mastectomy for in-situ (extremely early and noninvasive) breast cancer. Subcutaneous mastectomy with subsequent implant has been recommended also for lobular carcinoma in-situ but *not* for invasive cancer.

Recently, publicity has been sought about the possibility of not removing the breast

and using limited procedures instead, with or without postoperative radiation therapy, for some cases of breast cancer. The basis for recommending limited surgery rests on reports of only a few studies, particularly those done outside the United States, which suggest that survival from breast cancer discovered *early* and treated by limited surgery plus radiotherapy is equal to the results of removal of the entire breast. However, minimal surgery must be consistent with prolonged survival, freedom from recurrence and a satisfactory cosmetic and functional result.

Surgeons who favor removal of the entire breast and the lymph nodes in the axilla do so because this procedure has consistently offered a very satisfactory survival rate for early cancer. Also, this technique allows for the removal of multicentric cancers frequently found in other parts of the same breast as well as cancer which often involves the axillary lymph nodes and cannot be detected by physical examination. The surgical principle here is the removal of all possible existing cancer within the scope of the operation.

Studies on the various techniques of treatment of primary operable breast cancer are now underway in a number of U. S. institutions. However, it will take several years before the results are available. In the meantime, the policy of the American Cancer Society is the following:

1. Removal of entire breast (most often the radical or modified radical mastectomy) is recommended for surgical treatment of operable breast cancer.

2. Limited surgical procedures which remove less than the entire breast have not been scientifically proven to be as effective as mastectomy.

3. Recommendations for the treatment of breast cancer should be made by the physician on an individual basis only after careful evaluation aided by diagnostic studies. Such recommendations are related to the type, size, location, extent of tumor and other pertinent factors.

4. The patient and selected members of the family should be thoroughly advised by the physician about the proposed surgery and its rationale; this being the essence of informed consent.

5. The American Cancer Society is committed to rehabilitate the patient following surgery for breast cancer. The Society has developed the "Reach to Recovery" program which, at the request of physicians, sends trained volunteers who have had a mastectomy and have adjusted well, to visit mastectomy patients in the hospital. This program now brings information, psychological, cosmetic and physical rehabilitation to about one of every two women undergoing mastectomy in the United States. The Society takes the position that most of the physical and emotional problems related to mastectomy can be offset by planned rehabilitation. This, plus every reasonable chance for cure, is the right of every woman who develops breast cancer.

6. The American Cancer Society is continuing its support of research into the causes, detection, diagnosis and treatment of breast cancer as one of its highest priorities. It is our belief and hope that the tragic toll from this disease can be prevented by early diagnosis and early treatment. We also believe that American women should be well informed about these medical matters so that they may intelligently discuss these important considerations with their respective physicians.

7. Finally, any patient having breast cancer or indeed suspecting that she may have breast cancer, should consult a physician who is knowledgeable in this field, seek his advice and rely on his judgment in the selection of treatment for her individual medical situation.

Emergency Transportation of the Neonate*

PART IV

FRANK M. SHEPARD, M.D.
Department of Pediatrics,
Creighton University School of Medicine
Omaha, Nebraska 68178

The financial resources available for providing emergency transportation of the high risk infant were discussed at length at the conference. At the present time, Dr. Van Leeuwen describes their operation as a "shoestring" budget, with no identifiable budgetary items for support of personnel to provide transportation. The major financial resources have come from other activities of the University Medical Center. The manpower utilized has been primarily faculty members or pediatric residents in training, assisted by medical students.

The financial impact of private insurance carriers on newborn transportation was discussed by Mr. Richard Day of the Bankers Life Insurance Company and Mr. Glenn Margritz of Mutual of Omaha. Both commented on the increasing availability of insurance coverage either through individual policies or group policies. Both agreed that provision of emergency services for the high risk neonate was an important part of medical care and that the cost factor for an individual policy was minimal for a one-time service item, in contrast to the financial impact of coverage for chronic disability. The data were not available with respect to what percentage of the population has third party coverage that would pay for emergency transportation of the infant either by air or by ground. The impact of financing this for the medically indigent patient was also discussed. It was pointed out that in the state of Florida a significant portion of the costs are born by Services for Crippled Children, through the State Department of Welfare. This is currently not accepted as a reimbursable expense through Services for Crippled Children in the state of Nebraska.

The closing discussion at the workshop related to the identification of manpower to provide skilled care for the infant during transportation. As was previously mentioned, the pediatric house officers for the University of Nebraska Medical Center and a medical student assistant generally constitute the professional team utilized to provide care during the transportation of the infant. This has become a significant burden to the house officers at the University of Nebraska Medical Center. Two possibilities were discussed for expanding that coverage. One involved expansion to include other house officers and faculty of Creighton University School of Medicine, sharing the burden among the six neonatologists located in the metropolitan Omaha area. Another major aspect was the identification of individuals within local hospitals who had training in the care of the high risk infant, either physicians or nurses, who could assist in transporting the infant. One of the disadvantages of such a system is the frequent lack of alternate coverage for the individual at his local institution during the time when he or she is called to transport an infant to the referral center. The possibility of utilizing former medical corpsmen or physician assistants for such roles was discussed. Dr. Shepard spoke in favor of training former medical corpsmen to function in such a role for care of both the newborn and adult requiring emergency transportation. Dr. Van Leeuwen expressed significant reservations over the technical abilities of such an individual to intubate the small infant and to place umbilical arterial catheters. However, the possibility of providing supervision of his function by continuous radio contacts during such transport of the infant would minimize the problems associated with making therapeutic decisions.

Recommendations

The participants in the workshop were generally in agreement that the key to success in providing transportation of the high

*Proceedings of a Workshop held at Lincoln, Nebraska on May 23, 1973. Sponsored by: Division of Maternal & Child Health; Nebraska State Health Department; Nebraska Chapter, American Academy of Pediatrics.

risk infant depended strongly on the availability of an organized system for mobilizing resources and providing professional supervision during transportation of an infant at risk. The possibility of expanding the currently available services through exploration of private grant funds was mentioned by Mrs. Calista Cooper Hughes, director of Comprehensive Health Planning for the state of Nebraska.

The recommendations that grew out of the workshop are summarized briefly as follows:

1. The organization for facility and personnel to provide emergency transportation for the high risk neonate is basically a civic function, although private enterprise constitutes an important part of transportation facilities in both air and ground transport of infants.

2. The entry point into an organized system of care should be readily identifiable to all emergency facilities and hospital units in the state and adjacent areas. By the institution of a single phone call, a referring hospital or physician should be placed in contact with a neonatologist based at one of the major referral centers in the state who would be able to assess the individual situation and plan an orderly system of transportation and care designed to most expediently meet the needs of the individual patient.

3. Regional perinatal centers should be established throughout the state to serve as secondary care centers, alleviating the need for long transportation of infants and mothers in many instances. These secondary centers should have established relationships to tertiary care centers, both of which are currently located in Omaha at the two university medical centers.

4. Physical facilities to be utilized in such a transportation system must be diverse and utilized according to geographic location, climatic conditions, and relative urgency of the individual patient needs. Facilities should include the following:

   a. a source of rapid ground transportation, ie, an improved mobile hospital van that is less cumbersome and less subject to sway and wind turbulance at higher speeds.

   b. the identification of private air ambulance services willing to participate in such a system.

   c. the improved access to the resources of the Air National Guard for emergency transport purposes.

   d. the identification of private ambulance facilities equipped with power generators for transportation of infants either locally or for intermediate distances throughout the state.

5. The identification of physicians, nurses, and drivers for transporting infants must be expanded. The possibilities include the development of an on-call program involving pediatric house officers from both Creighton University and the University of Nebraska Medical Centers and a cooperative system of supervision by neonatologists of the two medical centers. The potential development of training programs for other health professionals such as Medex, nurse practitioners, and physician assistants should be explored.

6. An organized approach to financing emergency transportation services is mandatory. Identification and allocation of funds from state sources for central administration and supervision is needed. One possibility of funds might be through Services for Crippled Children as is currently carried out in Florida. Another major source of cost-reimbursement for an organized transportation program would be through private insurance carriers. Public awareness of the importance of this in group and individual policies is essential. Other possibilities of partial support for the developmental

stages for the organized system of transportation of high risk infants might include grant funds from private foundations such as the National Foundation — March of Dimes.

7. Expansion of already established educational programs for perinatal medicine is essential. Education of physicians, nurses and public of the need for early recognition of the high risk pregnancy and the early institution of referral of high risk mother for delivery at a regional center is important in minimizing the perinatal mortality and morbidity encountered in the small hospitals. Education of health professionals of the early recognition of signs of neonatal distress and the importance of aggressive intervention in treatment of the distressed neonate will continue to have a major impact on successful achievement of minimal perinatal losses.

The author wishes to express his appreciation to Dr. Robert Grant, Director of Maternal and Child Health of the State Health Department; Dr. Henry Smith, Director of the State Health Department, and Dr. Hobart Wallace, President of the Nebraska Chapter of the American Academy of Pediatrics, for their support and encouragement in conducting this workshop. The following were participants in the workshop:

David Bolam, M.D.
University of Nebraska at Omaha

Warren Bosley, M.D.
Grand Island, Nebraska

Alfred Brann, M.D.
University of Mississippi

Mrs. Vera Cross
Department of Pediatrics — Creighton University

Susan Currier, R.N.
Red Cross Representative—Lincoln, Nebraska

Sue Daly, R.N.
Head Nurse, Obstetric Nursery—Bergan Mercy Hospital

Lani Day, R.N.
Lincoln, Nebraska

Mr. Richard Day
Bankers Life—Lincoln, Nebraska

Mr. Michael Denker
Shurtleff Ambulance Company—Lincoln, Nebraska

James M. Donovan, M.D.
Omaha, Nebraska

Dale Ebers, M.D.
Lincoln, Nebraska

Charles Erickson, M.D.
Lincoln, Nebraska

Jose Estrada, R.N.
Scottsbluff, Nebraska

Kenneth Fijan, M.D.
Lincoln, Nebraska

Larry Fletcher, M.D.
Lincoln, Nebraska

Robert Grant, M.D.
Lincoln, Nebraska

Mr. Donald F. Hogg
Medical Services Division—State Department of Welfare

Mrs. Calista Cooper Hughes
Director of Comprehensive Health Planning—Lincoln, Nebraska

Mrs. Bess Jenkins
Lincoln Journal

John Jones, M.D.
Division of Maternal & Child Health—State Department of Health, Pierre, S.D.

Lt. Col. C. P. Korthauser
Highway Patrol

Col. James Krueger
Highway Patrol

Robert Luby, M.D.
Chairman, Department of Obstetrics-Gynecology—Creighton University

Mr. Glenn Margritz
Mutual of Omaha

Don McCammond, MSW
State Health Department—Lincoln, Nebraska

Matilda S. McIntire, M.D.
Division of Maternal & Child Health—Omaha-Douglas County Health Department, Omaha, Nebraska

Senator Shirley Marsh

Mr. Charles Marr
Assistant Administrator of Children's Memorial Hospital

Mary Merritt, R.N.
St. Elizabeth's Hospital—Lincoln, Nebraska

Elden Miller
Staff Coordinator—Civil Defense

Marty Miller
Eastern Ambulance Company—Lincoln, Nebraska

Jane Miller, R.N.
Obstetrics Nursery—St. Elizabeth's Hospital, Lincoln, Nebraska

W. Orr, M.D.
Department of Obstetrics-Gynecology—University of Nebraska Medical Center, Omaha, Nebraska

Milton Parker
Emergency Medical Services—Lincoln, Nebraska

Frank M. Shepard, M.D.
Chairman, Department of Pediatrics—Creighton University

Mr. Don Shurtleff
Shurtleff Ambulance Company—Omaha, Nebraska

Gerry Van Leeuwen, M.D.
Chairman, Department of Pediatrics—University of Nebraska Medical Center

Radiology Case of the Month

ROGER K. HARNED, M.D.
Department of Radiology,
University of Nebraska School of Medicine

THIS 73-year-old white female entered the hospital with a three month history of nausea and vomiting. She described fullness and abdominal distention after eating relieved only by vomiting. There had been a progressive weight loss of twenty pounds during this three month period. Figure one shows a prone view of the stomach and proximal small bowel during barium meal examination.

Figure 1

WHAT IS YOUR DIAGNOSIS?

1. Adenocarcinoma of the jejunum
2. Adhesion causing duodenal obstruction
3. Lymphosarcoma of the jejunum
4. Metastatic neoplasm to the jejunum
5. Granulomatous enteritis of the jejunum

ANSWER: Primary adenocarcinoma of the proximal jejunum.

Most investigators list carcinoid, adenocarcinoma and lymphoma, in that order, as the most common primary malignant neoplasms of the small intestine. Primary small bowel adenocarcinoma occurs more frequently in the jejunum than in the ileum and commonly presents with the clinical features of intermittent bowel obstruction, loss of weight and blood loss.

The roentgen appearance of a small bowel adenocarcinoma during barium meal study is usually quite characteristic. The lesion often presents as a short, annular filling defect, sharply defined with overhanging edges and ulcerated mucosa. It may ressemble the annular configuration of a

Figure 2

colon adenocarcinoma. Figures one and two well demonstrate these roentgen features. Note the dilatation of the duodenum immediately proximal to the constricting lesion.

Differential diagnostic considerations would include primary lymphosarcomas of the small intestine. The roentgen appearance of these lesions has been discussed in a previous case from this series. In general, they do not present as single, short annular lesions and obstruction is not a common clinical feature. Metastatic neoplasms to the small bowel are usually multiple and have eccentric and irregular contoured margins with larger ulcerations. The uncommon single metastatic tumor however, may mimic a primary adenocarcinoma. Hodgkin's disease of the small intestine produces a desmoplastic reaction causing narrowing of the bowel lumen that may resemble an adenocarcinoma.

Recommended Reading

1. Carlson HC, Good CA: "Neoplasms of the Small Bowel" in: Margulis AR, Burhenne HJ (eds): Alimentary Tract Roentgenology. Saint Louis, The C. V. Mosby Company, 1973, pp 865-902.

2. Good CA: Tumors of the small intestine. Am J Roentgenol Radium Ther Nucl Med 89:685-705, 1963.

3. "Primary and Metastatic Carcinoma of the Small Bowel" in: Marshak, RH, Linder AE (eds): Radiology of the Small Intestine. Philadelphia, W. B. Saunders Company, 1970, pp 329-354.

While Making Rounds

On Doctors.

There's only one little problem . . . you've got to be near death to appreciate them.

Will Rogers

Words We Can Do Without.

Without further ado, obsequious, quid pro quo, genteel, decimate, disadvantaged.

Quote Unquote.

Science is nothing but the determination to establish differences.

Hesse

Department Of Statistics.

You swallow every 70 seconds. That's over a thousand times a day, if you do it at night.

Section On Pediatrics.

Hypocrisy is not the parent's duty.

Shaw.

How Much Hemoglobin Do You Have?

On the Haldane scale, 13.8 gm per 100 ml of blood equals 100 percent. We always used 15.7.

Division Of Psychiatry.

Each individual is endowed from the beginning with its own peculiar dispositions and tendencies.

Freud.

On Muscle Relaxants.

. . . drenched with the hellish oorali.
Tennyson: In the Children's Hospital
That's curare!

That's What It Means.

Bursa: skin, hide.
Rhomboid: shaped like a kite.
Hamate: hooked.

The Diagnosis.

Minimal degenerative changes found in lumbar spine in both knees.

On Dominance.

Children usually make a choice of handedness by age three.

Quote Unquote.

When you talk to me, two people listen: you and I.

Anon.

The Population Explosion.

These are annual growth rates for 1973:

Albania	2.8%
Greece	0.8%
Iceland	1.2%
Netherlands	0.8%
Poland	0.9%
Portugal	1.0%
Rumania	1.0%
Switzerland	1.0%
United States	0.8%
Yugoslavia	0.9%

On Retiring From Medical Practice.

There is nothing wrong with retirement as long as one doesn't allow it to interfere with one's work.

Franklin

On Self-Determination.

Every step is known in heaven.

Singer

Something I Thought Of One Morning.

He submitted to his heart disease without a murmur.

Cole

—F.C.

Annual Distinguished Luncheon.

Annual Distinguished Luncheon.

Dr. John D. Coe delivering the Presidential Address at the Annual Distinguished Luncheon.

Doctor James H. Dunlap speaking at the Annual Distinguished Luncheon.

Doctor John D. Coe presenting President's Medallion to Doctor James H. Dunlap.

Doctor James H. Dunlap presenting plaque to Doctor John D. Coe.

Doctor John D. Coe presenting fifty-year certificates of recognition to fifty-year practitioners attending the Annual Distinguished Luncheon.

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President's Page

The recent action of the American Medical Association's House of Delegates meeting in Chicago June 23-28 has done nothing to change the Association's posture on Professional Standards Review Organizations.

After much debate in Reference Committee and no debate, but considerable swift parliamentary machinations on the floor of the House, the official attitude of the AMA remains as before, and is as follows:

> *Resolved*, That this House of Delegates instruct the Board of Trustees of the Association to direct its efforts to achieve constructive amendments to the PSRO law and to ensure appropriate regulations and directives, with particular effort directed at amending those sections of the law which present potential dangers in the areas of confidentiality, malpractice, development of norms, quality of care, and the authority of the Secretary of HEW; and be it further
>
> *Resolved*, That the Association should continue its efforts to achieve legislation which allows the profession to perform peer review in accordance with the profession's philosophy and the best interests of the patient; and be it further
>
> *Resolved*, That individual state associations which elect non-participation shall not be precluded from such a position by this Association's policy statement, but should be urged to develop effective non-PSRO review programs which embody the principles endorsed by the profession as constructive alternatives to PSRO; and be it further
>
> *Resolved*, That if ongoing evaluation of the PSRO program reveals that it does, in fact, adversely effect the quality of patient care, or conflict with Association policy, the Board of Trustees be instructed to use all legal and legislative means to rectify these shortcomings."

Of the many problems and objections to governmentally directed PSRO, three are of overriding importance; first, governmental encroachment upon our profession and the public; second, breaching of confidentiality of records; third, superimposition of norms and standards forcing inappropriate treatment.

Utilization review of medical services is, of course, the chief objective of the PSRO peer review concept, and the fact that this is aimed basically at cost control rather than quality control is disputed by only a few.

Organized medicine in Nebraska or elsewhere has a moral, ethical, and professional responsibility to police itself in all matters and this, of course, includes both cost and quality control. We would all much rather this would happen on a voluntary rather than a servitude basis.

Our Nebraska Medical Association's Ad Hoc Committee on PSRO has been changed with surveillance and contingency planning on this subject. To this end, our committee has much work to do to prepare prospective machinery for consideration by our own State Association House of Delegates in October 1974. Whether this machinery should be used outside of, or within the confines of a governmentally directed program is a choice our members must make.

J. H. Dunlap, M.D.

I Remember

THE PATIENT WHO GOT WELL IN THE AMBULANCE

On an ambulance call, you could treat the patient at his home or wherever you found him, but the important thing was to decide whether to bring him in to the hospital or not. If you missed the diagnosis, it was not too serious, just so you brought him in if he needed hospitalization, or if you left him at his home if that was the place for him.

And one fine summer afternoon, I found a patient who gave me double trouble. I did not know what was wrong with him, nor could I tell if he was seriously ill or not.

So after thinking and thinking for three whole minutes, I decided to bring him in. I must say here that I did not bring all my patients in. And all went well during our trip back to the hospital. Until we got to the hospital gates. Here we had to cross the courtyard, and drive some two hundred feet to the admitting area, which was a sort of platform.

And as we got to the gates, two funny things happened, unfortunately. The platform was always deserted, since there was no reason for anybody to be out there. But it was now full of people, the administrator, his assistant, several of the attendings, and worse still, some of my fellow-interns, and I can still hear them laughing.

For my patient now came wide awake, and the diagnosis was all too obvious. And as we approached my friends, he turned into a plain, loud, and roaring drunk.

Who of course did not need to be in the hospital.

—F.C.

Welcome New Members

Humberto G. Garcia, M.D.
Eppley Institute
University of Nebr. Medical Center
42nd and Dewey Avenue
Omaha, Nebraska 68105

Richard D. Juel, M.D.
Methodist Hospital
8303 West Dodge
Omaha, Nebraska 68114

Albert L. Steplock, M.D.
Red Cross
432 South 39th Street
Omaha, Nebraska 68131

David A. Wiebe, M.D.
123 West 31st Street
Kearney, Nebraska 68847

Jere Williams, M.D.
Central City, Nebraska 68826

Woman's Auxiliary

The Post Convention Executive Board Meeting of the Woman's Auxiliary to the Nebraska Medical Association was called to order by the President, Mrs. Kenneth McGinnis. Mrs. Guy Matson, in Mrs. L. Palmer Johnson's place, read the invocation.

The Auxiliary pledge was read and roll call was taken. Thirty recorded their presence. Three Directors, four District Councilors and two County Presidents were in attendance.

It was announced that the minutes would be sent to each chairman and would also be in the Nebraska Medical Journal. The Reading Committee appointed was Mrs. Charles Ashby, Mrs. Leland Olson, and Mrs. Harold Horn.

The Treasurer's report was read. The balance on hand May 1, 1974, was $2,214.16.

The temporary directories were distributed.

The President introduced the Executive Board and Committee Chairmen and Mrs. Howard Liljestrand, President-Elect of the Woman's Auxiliary to the American Medical Association. The President asked each officer to pass files and materials on to their

successors. She suggested that each auxiliary appoint a correspondent to the Newsletter and send information to Mrs. Robert Jones or Mrs. Warren Bosley.

Doctor Frank Cole, Editor of the Nebraska Medical Journal, asked for auxiliary news to be sent in by the first of each month with a 400-500 word maximum.

Mrs. Denham Harman, convention chairman, gave her report as follows:

> 118 registered, 55-60 attended the tour and luncheon at the University Hospital, 142 attended the luncheon at the French Cafe on Tuesday. She also gave the Douglas County report at the same time. They had had a pre-Christmas sale for AMA-ERF and they suggest a mid-week visitation to the Legislature instead of a legislative luncheon. The President thanked Mrs. Harman and her committees for the corsage, flowers and other courtesies.

Mrs. J. Whitney Kelley will continue to serve on the AMA-ERF committee. Her complete report will be given later. She was hoping it would be $10,000.

Mrs. Guy Matson gave her report on the Quality of Life Conference in Chicago, which she attended with Mrs. Warren Bosley and Mrs. Kenneth McGinnis.

The International Health Committee is collecting eye glasses and will continue.

Mrs. Robert Lovgren, legislative chairman, asked all of us to be aware and alert to health legislation.

A new committee with Mrs. Warren Bosley as chairman plans to emphasize communication.

High hopes were given by Mrs. J. E. Stitcher and Mrs. O. R. Hayes for the Health Gallery.

Mrs. Y. Scott Moore gave her report of the steering committee of the Inter-Agency Health Council. There will be a Health and Fitness Conference in the fall. She urged all to be there. It will be held in Lincoln on some football weekend.

Mrs. James Dunlap said that the loan and scholarship committee needs to make plans for the year.

Mrs. Leland Olson is selling memberships in the Nebraska MED-PAC. All should belong and during convention the price is $45.00 for doctor and wife.

Our 50-Year History committee, with Mrs. George Robertson, chairman, plans to meet in June. She emphasized the need to cooperate with the P.T.A. to promote Health Education in the legislature.

Mrs. Daniel Mergens gave her report of the County Leadership Seminar held in Chicago in February.

No bills were presented.

No unfinished business.

The new business included Article III—Executive Committee: Mrs. Leland Olson and Mrs. O. R. Hayes were nominated. Mrs. Robert Lovgren moved that the nominations cease. Mrs. Y. Scott Moore seconded it and the vote was taken and passed unanimously. It is hoped that this will be an effective committee and will plan to meet the first part of July.

Mrs. Warren Bosley will be the Presidential Delegate for the National Convention. Mrs. Kenneth McGinnis and Mrs. Leland Olson will be the two delegates from the membership. Alternate delegates are Mrs. Barney Rees and Mrs. James Dunlap.

It was suggested by the President that the State Officers and Chairmen keep in touch with the County Auxiliaries. She called attention to the list of dates to be remembered — as printed in the directory.

Fall Board Meeting — October 3-4, 1974

Fall Conference, Chicago — October 6-7, 1974

North Central Workshop, Hyatt House, Oak Brook, Illinois — October 17-18, 1974

Mid-Winter Board Meeting, Lincoln — Tentative date, February 6-7, 1975

Annual State Convention, Lincoln — Tentative date, April 27-30, 1975

National AMA and Auxiliary Convention, Atlantic City — June 15-18, 1975

Mrs. Howard Liljestrand, our gracious guest from the National Auxiliary, thanked the members for flowers and courtesies extended to her. She explained the new program for the coming year, answered questions and suggested that we should seek our own community needs first and then set goals to meet those needs. She announced that Mrs. Leland Olson is to be the new North Central Regional Chairman for Legislation.

The President introduced Mrs. Carl Sasse, a volunteer representing the Women's Guild of the Meyer Children Rehabilitation Institute. Diana Low, from the Institute, showed a film presenting the services, training and research being done for handicapped children of the state.

The meeting was adjourned.

Mrs. Bowen E. Taylor,
Recording Secretary

Presidential Address

Delivered May 1, 1974

It has been a great opportunity to have the privilege of serving as President of the Nebraska Medical Association. As a President-Elect, I tried to find out what was going on by attending meetings and I was grateful for this year of indoctrination.

I attended many committee meetings. I really found out the function of a great many aspects of this Association which I thought I knew about previously, but didn't. I am very grateful to those committees for educating me. I had served on a great many of these committees in my time in the Nebraska Medical Association and I learned invaluable information from those years of service likewise.

I have been a Delegate and an Alternate Delegate to the Nebraska Medical Association since 1953. I found it hard to believe that it is twenty-one years that I have been involved in this organization, but it is a great pleasure for me to have had the opportunity to serve as President of this organization.

Almost a year ago I spoke about the challenges which are presented to medicine and I had an enthusiastic list of things which I thought we might possibly accomplish during this ensuing year. As must be true for anyone who assumes a job like this, you soon find that you are not going to accomplish but a very few of the things that you set out to do. So, with that information I was trying to decide what shall I talk about, what shall I tell them that I did during my year as President of the Nebraska Medical Association. At every committee meeting that I attend, or every coffee room conversation, or for that matter some serious addresses, it is fashionable to have "good news" and "bad news." I haven't a "good news" and a "bad news" joke for you, but I am going to tell you today about the "good news." We have discussed "bad news" in great detail, we've labored over it word by word, and I'm going to tell you about the "good news."

We're going to skip a great many of the socioeconomic problems which do beset us and which require all our attention and our thought and hard work. I want to tell you that the great majority of Nebraskans are healthy. I want to tell you that the large percentage of all babies born in the State of Nebraska survive the first dangerous year. This has not always been the case. There are unprecedented numbers of Nebraskans living into their seventies and eighties and this increased longevity due to their improved health in great part causes much of the concern which we have about over population and all the problems involving ecology which we have all learned to think about. I would also like to remind all of you, and to refresh the memory of those fifty-year honorees, that there was very little need for

population control fifty years ago when great numbers of deaths from disease and infant mortality really solved the problem.

The Nebraska Medical Association has had a great deal to do with many of the great killers which have been banished by effective public health measures. You can drink water anywhere in the State of Nebraska without fear. You can buy a bottle of milk anywhere in this state without fear. There was a time when tuberculosis, typphoid, and many of the other dysentery diseases were very serious problems in this regard. No one speaks anymore about the sanitary disposition of sewage. That has been solved throughout the state and food inspection is carried out in the entire state with protection for all the people who buy that food.

One of the things that has happened also in these past many years is our affluence which has provided good nutrition. Good nutrition and increased wealth has produced some other medical problems which I am sure we did not foresee many years ago. Some of these are many more deaths and serious accidents from automobile accidents. Who would have dreamed fifty years ago that this would be the chief cause of trauma in an agricultural state. The matter of affluence and good nutrition has produced many problems in regard to the heart and vascular diseases. Perhaps our sedentary living is not all that good. Obesity certainly is a persistent problem which many of us have a great deal of trouble in dealing with.

There are many specific diseases that in the last many years have been conquered. Tetanus for example. There has been only a rare case of tetanus since World War I.

When I started in practice, polio was the scourge of this state with young children at that time. In 1952, there were 456 cases. At the Children's Hospital in Omaha, there were 90 active polio patients in the hospital. Stop and think about how long it has been since any of you have seen a case of polio.

Rheumatic heart disease, a very important disease when I was a medical student. We talked about how we were trying in some manner to cure and alleviate this horrible situation which not only produced an acute infectious disease, but left scars on the heart that really made it very difficult for these people to survive. That is practically gone. Preventive medicine and antibiotics have abolished it.

To go back a few years and recount just a few items for you. Insulin was discovered just about the time these gentlemen went to medical school for the treatment of diabetes. We accept it with all the refinements of it in the treatment of diabetes without any thought, but there was a time when diabetes was a very difficult problem to deal with.

B 12 in liver extract is used for pernicious anemia. It came into use in roughly 1924.

Vitamins came into being in 1935, then along about the same time in 1935 came the sulfa drugs, penicillin in 1942, the mycins in 1944 and 1945, and from that time on all of the broad spectrum antibiotics which have really changed the whole scope of our medical practice. Cortisone became available in 1952.

There are innumerable other lesser items of concern. The most recent and probably the most exciting thing that we have talked about in the last several years is organ transplantation. All of the doctors in the room recognize that probably heart transplantation is not going to be a thing of any real consequence. It was very dramatic, a very courageous thing which was done. Kidney transplantation has become an established procedure which has saved the lives of innumerable people. We have a complete transplant program here in Omaha. It is a remarkable thing that you can take an organ from one person and transplant it into another person.

Now let me give you a little aside as to transplantation. One may think the organ transplantation was all wasted because of the tremendous amounts of money that were spent in research in how to do this, I am convinced that the "immuno-suppressive" techniques which were used to maintain these transplanted organs is some day going to give the basic biological information which will be able to answer the problem of cancer. When they can decide by their "immuno-

suppressive" drugs when a cell will reject, when a cell will live, when it will multiply; I have no doubt that some day some research man will have the ability by manipulating the enzyme change in the cells to cure cancer.

Enough of all the good things that have happened to us. I want to make a comment about some changing patterns in health care delivery mostly as it applies to this state.

The individual practitioners, the so-called "cottage concept" of care, is phasing out in part. Years ago every village, every crossroad had their doctor. He took care of the patients in that area and there was very little if any interchange of either doctors or patients. The method of practice now primarily is that of hospitals serving doctors in a community. In other words, the doctors are still in the area, but they take their patients to a hospital where they can give them a little more scientific care.

We have noticed the growth in this state of multiple office practices over the years partnerships and group situations. Doctors found they could work more efficiently, more scientifically, and effect better cures by grouping together and sharing their talents and their abilities.

What about hospital-based practices. We have none of that in this state as of yet, although certainly it may be a thing of the future. It may be in two or three generations that the hospital will be the unit to which we go for medical care. They then will provide whatever type of medical care we need be it medicine, nursing, or whatever.

I mention HMO (Health Maintenance Organization). This set of initials has become popular and used by many people without really understanding what they are talking about. It is prepaid medical care. In general we do not endorse this, but this year before the State Legislature the Nebraska Medical Association testified in the favor of HMO enabling legislation in this state. We feel that we must provide a multiple type of medical service in this state. HMO legislation would be one of the methods of providing service and if it is provided in an ethical, scientific manner we have no objection.

What about our changing patterns in education of the health care professional? At the University of Nebraska, we have gone from a four to three-year curriculum. This is not without some concern and some objection not only from the faculty, but from the students. As a matter of fact, it seems to me that the students are most concerned of all about this three-year curriculum.

Medical education is different than it was years ago. It is much less didactic, much more practical. Third and fourth-year medical students, in academic years as we think about them, spent little if any time in class. They spent all their time at the bedside and services in hospitals. The method of teaching has changed entirely.

What about the attitudes of the medical student? We complain in Omaha, those of us who deal with them periodically, that there is much less formality; much more casual dress; there are more beards; more familiarity; and above all of this they have time for political activities. I can't ever recall seeing any of my fellow students out with a sign walking up and down on the street, but this group in addition to learning medicine has time to engage in political activity and I suspect that this is all good.

What about nursing? There are two types of nursing education available now which were not available previously. In addition to the regular RN designation after three years of education, there is now a four-year degree nurse a much more sophisticated and more academic-oriented type of person who will probably at least in the onset start out in administrative affairs of some sort. We have many practical nurses. We have many nurses aides and indeed they do provide the actual bedside nursing which for a long time everybody thought was a bad situation, but it is remarkable to see how well hospitals function under this circumstance.

In Nebraska, we have been interested in and have instituted physician's assistants. We have a pilot program at the state university. We don't know exactly what it is going to lead to. We don't know if it is

going to solve all of our problems. I would like to say this to the allied health people. We have no desire whatsoever to replace or surplant any of them. This program came about because of a need for more people to try to deliver more medical care in the State of Nebraska.

What about changes in patterns in our Nebraska Medical Association membership? We are dealing with younger people, we are living in the "Age of Accountability." Unless we can point out to these gentlemen and ladies why they should be members of the Association, they are not going to join. I thought about this for a while and it occurred to me that the old needs of twenty years ago, fifty years ago, or seventy-five years ago for that matter of scientific association is somewhat not as important as it used to be. The NMA used to be the only medical meeting in the State of Nebraska.

I would also like to remind you that travel these days is commonplace. It is not unusual whatsoever to find a doctor in outstate Nebraska who has been to Vancouver, B.C. or Honolulu, Hawaii or Guadalajara, Mexico to a refresher course. He thinks nothing of hopping on a plane and running off. So, we are mobile just like everyone else.

We have also found in talking to these people that young people think membership in our organization is expensive, and indeed it is expensive. We feel it is worth the money.

There are other organizations in the state which you are aware of. The American Academy of Family Physicians, which next to the Nebraska Medical Association has the largest number of members in this state. Many of you are members. The American College of Surgeons, the American Society of Internal Medicine, plus specialty societies for almost every group.

In regard to geographic distribution of physicians, there are less individual rural doctors and there is great concern of the small communities of this fact. The Rural Medical Day at the University within the past month, indicated that many of these smaller towns still are greatly concerned about the fact that they cannot obtain a doctor. Practices in Nebraska have reverted to the larger medical centers, to Lincoln, and to Omaha, but beyond that to the medical centers out through the state. Many of the towns from 10,000 to 20,000 throughout the state have medical centers of their own and are drawing in a great many of the patients.

We have spent some time this year trying to encourage membership. I made a personal appeal for membership to each new man who I was aware of that had gone into practice. I wrote him a letter asking him if he wouldn't consider joining. I found out in talking to young people that most everybody wants to be asked to join the medical association. We have tried to involve our Councilors in this regard and they are working in that regard.

We have also by the way in trying to improve our membership, become concerned with students and house officers. This matter primarily involves Omaha and Lincoln in-so-far as providing some type of a special category of membership for these people. It must be quite obvious to you that they are only here for a short period of time and they can't come up through the ordinary channels as an ordinary practicing physician can. We must provide some method by which they can get into the system. It takes much less dues. We have made those arrangements. We are working hard with the young people at the University in trying to get them involved. We now have four students and four house officers in the state who are members of the House of Delegates of the Nebraska Medical Association.

We have changing patterns in continuing education. The Nebraska Medical Association and the American Medical Association have always been interested in continuing education and this interest is becoming more formalized. I must say both of those organizations have been stimulated by the American Academy of Family Physicians for their continuing education, their credit hour determination. This is of particular importance when you think of the emphasis of continuing education on relicensing and recertification. There are two states in the union now New Mexico and Oregon in which this law is in effect. We are making great

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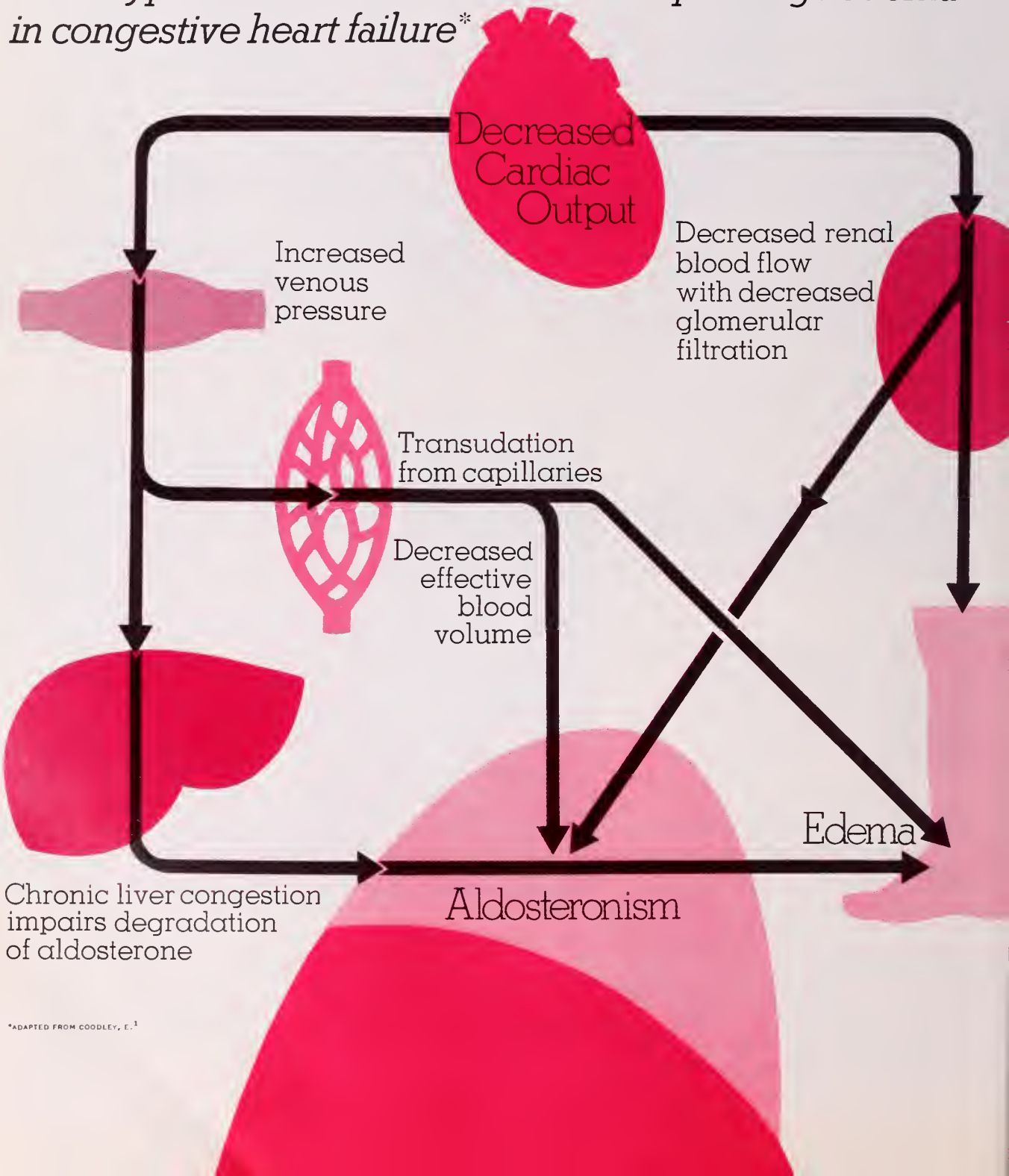

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- Can be administered daily as basic therapy with the additional agent (furosemide or ethacrynic acid) given every second or third day.
- Aldactone plus "A.D.D." schedule minimizes potassium deficiency and potentiates effect of "add-on" diuretic.[2]
- Avoids acute volume depletion and aldosterone rebound.[2]

3. As a daily diuretic in combination with a daily dose of a thiazide
- Permits daily additive diuretic effect while maintaining potassium balance.

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: 1. Coodley, E.: Consultant 12 106-107, 109, 111, 113, 115 (July) 1972. **2.** Thorn, G. W., and Louler, D. P.: Am. J. Med. 53 673-684 (Nov.) 1972.

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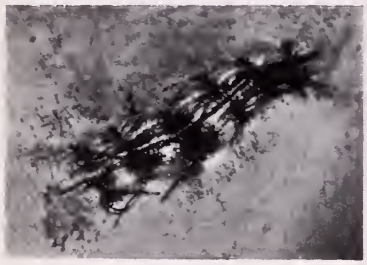

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efforts through the Medical Education Committee and both of the Universities to increase the Nebraska Medical Association's participation in this venture.

We have a changing attitude in health planning. Planning techniques and planners are now in vogue. We have adopted a committee in this state the Health Planning Committee chaired by Doctor Cottingham which is functioning, making surveys and we are trying desperately to get involved in the planning techniques for medical care in this state. It may very well be that we will have to hire some professional help in this regard as time goes on. We are very much involved in comprehensive health through the state level here in Omaha the Health Planning Council of the Midlands, the Southeast Nebraska Council, and the one in Kearney, Grand Island, and Hastings.

So, if you make a critical analysis of the practice of medicine in my judgment it is still very encouraging. Now many of our accomplishments are overshadowed by our critics. I really felt this was my main reason for mentioning these things to you again. We forget what fabulous strides we have made in medicine in the past fifty years. I would point out to you that in the most recent popularity polls of individual professions the physicians stood at the top. The most remarkable thing about it all is those who really criticize us most severely, still have a great regard for their own personal physician.

Medicine still provides an exciting opportunity to practice an art, to deliver a skill, and to provide a service.

John D. Coe, M.D.

The Letter Box

Dear Doctor Cole:

The AMA has not taken a stand on the issue of the optimal surgical treatment of breast cancer.

I realize that there is a controversy in this area of medicine and it is important that all sides of the question be thoroughly aired. I want to commend you for planning an issue of the NEBRASKA MEDICAL JOURNAL directed to this problem. I would greatly appreciate a copy of the proposed articles when they are ready for press so that I might distribute them to members of the AMA Cancer Committee for their information.

Sincerely,
William R. Barclay, M.D.

Dear Dr. Cole:

Since we have been fortunate enough to get on the mailing list for *The Nebraska Medical Journal* our staff has enjoyed reading this excellent publication. The magazine covers are especially attractive, but the June cover hits a new high.

I personally enjoy your editorials. They are well written and thought provoking. When I read the editorial in the June issue entitled "On Wasting" I was reminded of a statement of Dean J. Douglas Brown of Princeton University who compared the body of the community with the human body in a rather memorable quote . . . "Without countervailing tension the human body falls into a heap, to sleep, if not to die. Without countervailing tensions and ideas a community decays from sheer inertia. It is the way in which tensions are resolved that tests the quality of a community, not their absence."

Again my congratulations on a fine professional journal.

Sincerely yours,
Susan S. Jenkins
Program Officer
Health Insurance, SSA

WashingtoNotes

National health insurance

The humdrum hearings on national health insurance (NHI) before the House Ways and Means Committee got something of a lift when the long-absent chairman, Wilbur D. Mills (D.-Ark.), unexpectedly showed up one Friday in mid-June and announced that whatever bill his committee approves undoubtedly would not look like any single bill presently under consideration.

The lack of interest evident in the House Ways and Means Committee hearings — only two or three members attending each hearing and chairman Mills showing up for just the second time in months — and the indefinite postponement of Senate Finance Committee hearings would seem to say Congress is not trying hard to pass such a bill this year.

Mills said his own plan (Mills-Kennedy) "doesn't do everything I would like it to do." He said, however, he believes the method of reimbursing physicians under Mills-Kennedy is better than under Medicare. It would eliminate the apparent discrimination between the city physician and the rural physician, Mills believes.

Here are selected sample bits of testimony from the many medical-health care oriented organizations who have trooped to Washington to have their say about NHI:

The American Public Health Association urged more consumer policy input than provided in any of the major NHI bills before the committee and more preventive services benefits.

The American Association of Medical Clinics supported maintenance of the free enterprise system of health care, and said funding should be from mandated employer plans and general tax funds for the poor and medically indigent.

The Colorado Health and Environment Council witness discussed the Colorado Community-Cooperative-Decentralized plan which emphasizes preventive medicine and home health care.

The National Association of Social Workers favored the Kennedy-Griffiths, Health Security Act provisions.

The American Academy of Family Physicians told the House Ways and Means Committee any NHI bill must provide that family physicians receive the same fee as other specialists when providing the same service.

Ned Parish, President of the National Association of Blue Shield Plans, said the concept of a totally tax-supported and government administered national health program is "a solution for a problem which no longer exists."

He called for:

—Federal financing of coverage for the poor and medically indigent.

—Catastrophic coverage, not federally-financed, tied to a program of basic benefits.

—Regulation of carriers with respect to covered benefits and solvency.

—Minimum standards for coverage.

—Free choice and maximum participation by the private sector.

In other testimony, the U.S. Chamber of Commerce urged approval of its own mandated-coverage NHI plan as "realistic, reasonable and affordable." The Mills-Kennedy plan would lead to "federal domination of the health program" and impose excessive new payroll taxes, the Chamber said. The Administration's "CHIP" plan would significantly increase costs to small and medium sized businesses and the AMA's Medicredit plan is not comprehensive enough, according to the Chamber.

Pharmaceutical Manufacturers Association President C. Joseph Stetler said the Mills-Kennedy bill provision for a restrictive national formulary for out-patient drugs would distort prescribing decisions. The PMA is most concerned with the proposed price controls on drugs, Stetler testified.

This would force a diversion of sales from research-based firms to the non-researching sector, he said.

The National Protestant-Catholic Hospital Association said the Mills-Kennedy bill does not adequately ensure that hospitals will be reimbursed for their costs and could force non-profit hospitals "into a hand-to-mouth existence." Voluntary donations would cease, the Association warned.

Consumer Federation of America — favored the labor-backed Health Security bill, and argued that sole reliance on payroll tax as in Mills-Kennedy is regressive. The Federation indicated it would prefer a program financed solely out of general revenues.

National Cancer Foundation — all bills fall short of providing adequate catastrophic coverage.

The National Association for Mental Health — legislation should emphasize outpatient services and stimulate Comprehensive Community Mental Health Centers.

National Kidney Foundation — "We have major trepidation about the ability of existing administrative machinery to manage a NHI program of far greater dimensions and scope than the end stage renal disease program."

University of health sciences

P. O'B Montgomery, M.D., of Dallas, has been nominated by the President to the Board of Regents of the new Uniformed Services University of the Health Sciences.

Dr. Montgomery, a professor of pathology at the University of Texas Southwestern Medical School, was named to serve the remainder of the four-year term of Anthony R. Curreri, M.D., recently appointed president of the new school. The nomination goes to the Senate for approval.

Medical deductions

Working on a sweeping tax reform bill, the House Ways and Means Committee tentatively has decided to change the tax laws affecting medical deductions and business expenses that would affect consumers and physicians.

Apparently with an eye on the possibility of a national health insurance program being enacted, the Committee voted to remove the present deduction for one-half the amount an individual pays for his health insurance premium (up to $150), and to increase the present three percent of income floor applicable to medical expenses to five percent. The one percent of income test for drug costs would be abandoned, with the drug expenses coming under the five percent medical expenses category. Only prescription drugs would be covered.

In addition, the Committee decided to do away generally with the sick pay exclusion under which a tax break is provided employees who are paid while sick beyond a certain length of time.

Coming Meetings

CRIPPLED CHILDREN'S CLINIC —
August 3 — Scottsbluff, St. Marys Hospital
August 10 — Norfolk, Elks Lodge
September 21 — McCook, St. Catherine's Hospital

AMERICAN CANCER SOCIETY'S NATIONAL CONFERENCE ON GYNECOLOGIC CANCER; September 18-20, 1975, Marriott Hotel, Philadelphia, Pennsylvania.

AMERICAN CANCER SOCIETY — National Cancer Institute — Eighth National Cancer Conference; September 20-22, 1976, Regency Hyatt Hotel, Atlanta, Georgia.

NEBRASKA MEDICAL ASSOCIATION — Fall Session, October 3-5, 1974, Lincoln, Nebraska.

ANTIBIOTICS AND INFECTION — The Fifth Annual Meeting will be held at the University of Iowa Hospitals, Iowa City, on October 24th, 25th and 26th, 1974. Write to: Dr. Ian M. Smith, Department of Medicine, University of Iowa Hospitals and Clinics, Iowa City, Iowa 52242.

OMAHA MID-WEST CLINICAL SOCIETY — 42nd Annual Postgraduate Assembly, November 11, 12, and 13, 1974, Omaha Hilton Hotel. Write to: (Mrs.) Mary E. Pilloud, Executive Secretary, 1040 Medical Arts Building, Omaha, Nebraska 68102.

AMERICAN ASSOCIATION FOR CLINICAL IMMUNOLOGY AND ALLERGY — Annual Meeting; Pier 66, Ft. Lauderdale, Florida, November 21-24, 1974. Write to: John L. Dewey, M.D., P. O. Box 912, DTS, Omaha, Nebraska 68101.

AMERICAN CANCER SOCIETY — National Cancer Institute — National Conference on Advances in Cancer Management; Part I, Treatment and Rehabilitation, November 25-27, 1974, Waldorf-Astoria Hotel, New York City.

AMERICAN MEDICAL ASSOCIATION — 28th Clinical Convention, November 30-December 4, 1974, Portland, Oregon.

NEBRASKA MEDICAL ASSOCIATION — Annual Session, April 27-30, 1975, Lincoln, Nebraska.

AMERICAN CANCER SOCIETY — National Cancer Institute — National Conference on Advances in Cancer Management; Part II, Detection and Diagnosis, May 1-3, 1975, The Denver Hilton, Denver, Colorado.

AMERICAN MEDICAL ASSOCIATION — Annual Convention, June 15-19, 1975, Atlantic City, New Jersey.

Turn Back the Clock

DOWN MEMORY LANE

1. Various names have been given to this factor, such as "incoagulable nitrogen," "filtrate nitrogen," "non-dialyzable nitrogen," "rest," "waste," or "retention nitrogen," but the term non-protein nitrogen is at present employed almost exclusively.

2. Long continued stimulating action of roentgen ray on previously normal tissues may convert this tissue into cancerous tissues, carcinoma or sarcoma.

3. Sextuplets are rare, one authentic case being reported in which a woman at the fourth month of pregnancy gave birth to two female and four male children.

4. To just the extent that the general practitioner asserts himself by showing his generalship and proves his usefulness to his patron and patient he will be appreciated and likewise will need worry less about getting a slice of the surgeon's fee.

5. Is the value of the determination of the number of white blood cells in many conditions, and especially in the acute abdomen, fully appreciated?

6. Twenty-six former presidents of the Nebraska State Medical Association are living, all but three in Nebraska.

7. In these days, when the successful treatment of many cases of diabetes rests so much on the proper balancing of the dosage of insulin against the diet of the patient, it is most important to remember that the main thing to avoid in the use of this most valuable therapeutic agent is the production of a hypoglycemia.

8. In the past, the one-stage operation of resecting the diverticulum immediately and trying to close the oesophagus, was met with a high mortality because the oesophageal tissues tend to tear easily and it is a difficult procedure to close these tissues so there will be no cutting or leakage in the suture line.

9. There is today too much "use this injection and come in next week" or "here, take your irrigation, you will soon be well."

Nebraska State Medical Journal

August, 1924

Medicinews

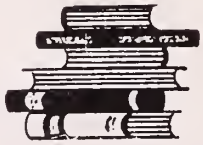
Hill-Burton

The Health Facilities Assistance Act of 1974, S. 3577, a three-year replacement of the Hill-Burton program, was th e subject of hearings before the Senate Health Subcommittee. The new plan would assist construction and modernization of public or other nonprofit outpatient facilities and the modernization of facilities in shortage areas. The first witness before the Subcommittee was Charles C. Edwards, M.D., Assistant Secretary for Health. Dr. Edwards called for major modifications in the bill, specifically criticizing the continuation of formula grant programs designed to aid facility needs in undeserved urban and rural areas, since such a program "could require unacceptably large appropriations in order to reach needy areas that exist in many states." As an alternative to S. 3577, Dr. Edwards called for a capital assistance effort through direct project grants. "Such grants would be available to public and private nonprofit health care facilities that . . . serve large numbers of poor patients and are unable to obtain a loan through the private capital market without federal capital assistance." Under the Administration's plan, the size "of the federal share would be limited and the grantee institutions would be enabled to par-

ticipate in the normal debt servicing arrangements. The grants would be limited to provide financial assistance for modernization (and replacement) of currently existing hospital facilities including outpatient departments. Assistance would not be available for the construction of new facilities nor for the replacement of an existing facility if it would worsen the access to those now being served."

Also testifying before the Subcommittee was Leo Gehrig, M.D., Vice President of the American Hospital Association. Acknowledging the pressing need to modernize and renovate facilities, particularly in major cities and in some rural poverty areas, and noting the growing demand for additional outpatient facilities, Dr. Gehrig disputed figures and studies indicating that additional hospitals are not needed in the United States. He called for authorizations twice the amount of those in S. 2577 and recommended several changes in the bill, primarily extending the existing Hill-Burton program and establishing modernization grants, urban facilities programs, and outpatient facilities construction programs. Dr. Gehrig further recommended development of certificate of need laws in every state for the regulation of hospital construction and development. Although he stated AHA favored the "conversion" of hospital beds which were not being used, Dr. Gehrig contended that "mothballing (of hospital beds) should be the last resort."

Books



Hans Selye: Stress Without Distress; 171 pages; $6.95; hard cover; published 1974 by J. B. Lippincott Company, Philadelphia & New York.

I do not need to tell you who Hans Selye is. He is an M.D., and he is of course the authority on stress. Without getting past the frontispiece, a Selye book on stress must be good. Besides, the print is excellent, there is a bibliography, a glossary, and an index. There are marvelous pictures, including a Karsh portrait of the author and a friend; and one of a teacher and her student that, even if it is posed, is the best picture of a teacher I have ever seen.

But I have read every word in the book, which may not be standing procedure in book reviewing, and I found myself deluged by copybook maxims that seemed unfortunately dishwatery and unwarranted. Stress is not what we think it is, and I will believe Dr. Selye. But he says that cell stress and people stress are not unlike, nor is nation stress. Recommendations for human behavior go back to the cellular and even the molecular level; the solution is altruistic egotism, which he explains. This is somehow illustrated by cancer, which kills its host and commits suicide.

He is one with Osler on the necessity to work; and deprivation of motivation is tragedy. But it is hard for someone who has been successful to give you advice. What worked for him may not work for you, and anyway, he may not really know what did it for him. If he got up early and worked hard all his life, there is the chance that it will not help a thousand of his readers. And what he says may be pure wisdom or may be the veriest pap. I have got up at five (he rose at four), and I have written books, but not about getting up at five.

This may be a very good book, even if I am not convinced.

—F.C.

Elliott S. Kanter: Servicing Biomedical Equipment; 160 pages; paperback, $5.50; published 1974 by Howard W. Sams & Co., 4300 West 62nd St., Indianapolis, Indiana 46268.

The author is a member of the Department of Biomedical Engineering, Cook County Hospital, Chicago, and has published many articles in electronic servicing journals. The index includes references to the electrocardiograph, suction pumps, defibrillators, oxygen systems, nebulizers, flowmeters, centrifuges, and monitoring devices.

This book shows you how to keep these devices in order. The hospital is full of these things, and it is good to have a book of this kind. There are fortunately pictures and diagrams on most of the pages.

The book has 13 chapters, a long appendix, and a tiny bibliography. It is well written and well printed. I like what he had to say about "The Hospital, a Different Sort of Customer," and "Teach to Learn."

—F.C.

Scheingold, Lee D. and Wagner, Nathaniel N.: Sound Sex and the Aging Heart; 168 pages; hard cover $7.95; published 1974 by Human Sciences Press, 72 Fifth Ave., New York, N.Y.

This book is written for nonphysicians, as its glossary implies, but doctors read books about sex, too, and it may be that they should. One author, taking them in alphabetical order, is a female M.A. who has worked as Clinic Administrator at Seattle Cardiac Work Evaluation Clinic and as a counselor at the Seattle Mental Health Institute; the other is a male Ph.D. who specializes in family planning; the preface is written by a male M.D.

Is sex a strenuous form of exercise? Ought one (or two) to take it easy after illness or injury or middle age? That is what this book is about.

There are references, unfortunately two glossaries, an index, and the customary allusions to Masters and Johnson and to others; and there are the usual assurances.

A nice book, if you can call a sex book nice. I can.

—F.C.

Bilateral Carcinoma of Breast — N. D. Wilson (Dept of Surgery, St. Vincent Hosp, Portland, Or 97208) and R. E. Alberty. Am J Surg 126:244-248 (Aug) 1973.

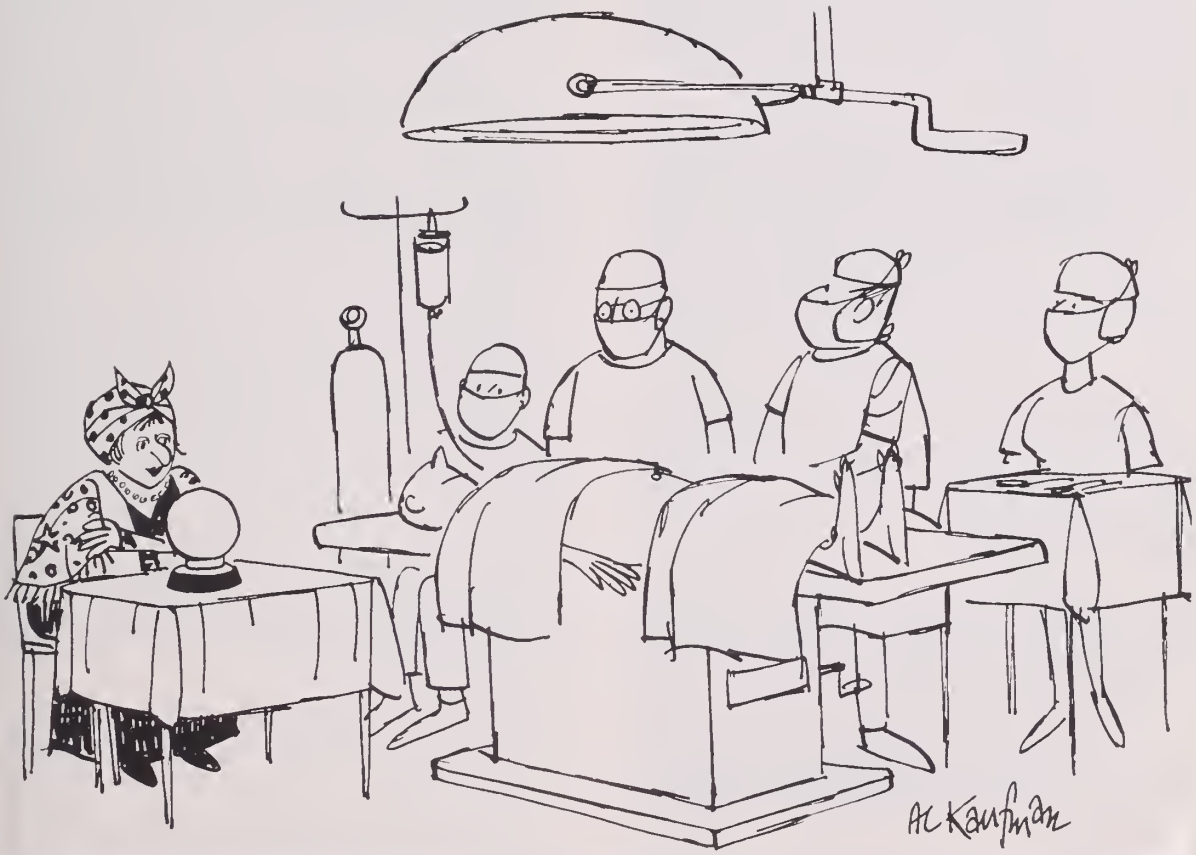
A clinical profile of 119 cases of bilateral carcinoma of the breast is presented. Survival rates in the nonsynchronous group are higher than those reported for unilateral disease. Nonsynchronous tumors (those with more than a 12-month interval between occurrences) should be considered new primaries.

Use of Water Bed for Prevention of Pressure Sores — R. J. Siegel et al (Stanford Univ Hosp, Palo Alto, CA 94305). Plast Reconstr Surg 51:31-37 (Jan) 1973.

The magnitude of the pressures produced under the bony prominences of ten volunteers was tested on the water bed, using a hospital bed as a control. When correctly filled, the water bed generally provided pressures of less than 20 mm Hg (capillary pressure). The outstanding exception was the calcaneal area, where a mean pressure of 27.2 mm Hg was recorded. Use of the water bed may be an important part of prophylaxis against pressure sores in paralyzed patients.

Nervous System Involvement in Ankylosing Spondylitis — D. J. Thomas et al (Queen Elizabeth Hosp, Birmingham, England). Br Med J 1:148-149 (Jan 26) 1974.

Forty-five unselected patients with ankylosing spondylitis were reviewed to assess the frequency of nervous system involvement. Ten patients had neurological symptoms and signs. Of these, two had disseminated sclerosis, one had spastic paraparesis, one had cauda equina syndrome, two had symptoms of vertebrobasilar insufficiency, two had focal epileptic fits, and in four there were peripheral nerve lesions. An association between ankylosing spondylitis and disseminated sclerosis-like illness is suggested.



"She's just filling in while they repair the equipment to monitor the patient's status."

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FOR SALE, RENT OR OTHER AGREEABLE ARRANGEMENT — Medical office with active practice. South-central county seat town of 1500. New hospital and nursing homes. Three other physicians in county, only one is full-time, active. Contact: Box #46, Nebraska Medical Journal, 1902 First National Bank Building, Lincoln, Nebraska 68508.

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GENERAL PRACTITIONER — Excellent opportunity to take over a well-established practice for the price of equipment. Better than average yearly income. Will introduce for one year and guarantee income. Located in suburb of Omaha. If interested, contact Box #49, NEBRASKA MEDICAL JOURNAL, 1902 First National Bank Building, Lincoln, Nebraska 68508.

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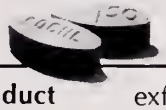

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Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species).

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Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, allergy or bronchial asthma; and in those with glucose-6-phosphate dehydrogenase deficiency, where hemolysis may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12.

Usual adult dosage: Two tablets b.i.d. for 10 to 14 days. For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

Supplied: Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10.

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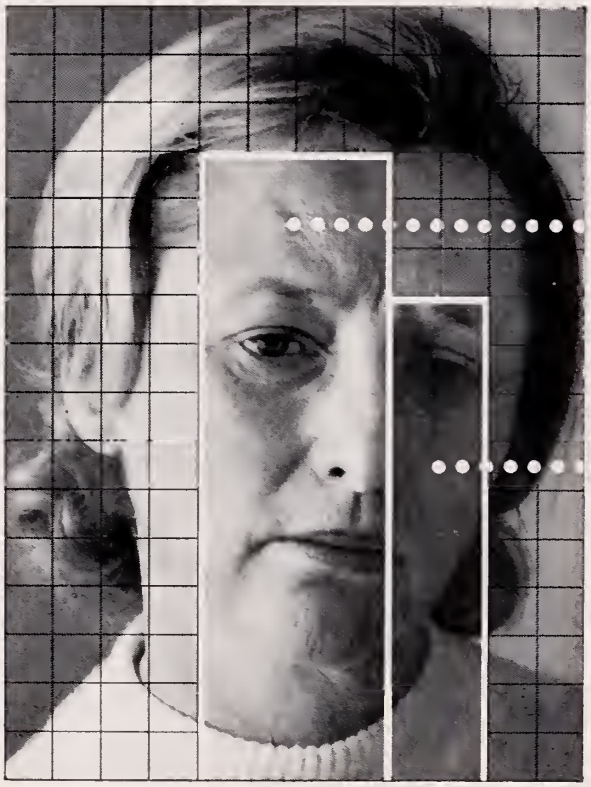

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The Nebraska Medical Journal

EDITOR — FRANK COLE, M.D., 1845 "F" St., Apt. 1, Lincoln 68508
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When the patient on uricosuric therapy requires an analgesic, a new problem arises. Aspirin in the usual analgesic doses inhibits the action of uricosurics.[1,2]

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References: 1. Martin, E.W., et al., ed.: Hazards of Medication, Philadelphia, J.B. Lippincott Co., 1971, p. 511. **2.** Seegmiller, J.E.: Med. Clin. North Amer. 45:1259-1272 (Sept.) 1961.

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Manuscripts to be presented for publication in the JOURNAL should be typewritten, double-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title-page should be shown the title of the article, the name (or names) of the author, his degree and other significant credits. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Illustrations should be numbered and their locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be in black (India ink) on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

Manuscripts (original, not a carbon) should be sent directly to the Editor at the Journal's address.

Letters to the Editor submitted for publication should be prepared as above, and must carry the notation: To be Published.

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OCTOBER IS

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IMMUNIZATION
ACTION MONTH

Medicinews . . .

National health insurance

It has been reported that the House Committee on Ways and Means may begin hearings for the purpose of preparing national health insurance legislation. The schedule for these hearings has not yet been released, but the initial session is expected to continue at least until the impeachment debate begins on the House floor. The impeachment debate is expected to be completed by the Labor Day recess. The NHI mark up would probably resume after the recess and final consideration of tax legislation currently pending before the Committee. The Committee is scheduled to complete its initial mark up of the tax amendments, and the policy decisions of the committee will then be set forth in legislative language. Upon the completion of this procedure the committee will review the proposed language and make any appropriate modifications. Under the expected schedule, therefore, the Ways and Means Committee will be considering both the tax amendments and proposed national health insurance plans in the weeks to come.

With respect to the tax amendments it is understood that the Committee is still considering provisions to treat the first $200 of expenses for professional memberships and publications as non-deductible expenses. The Committee is also considering a proposal to bar the deduction of the cost of business trips outside the United States.

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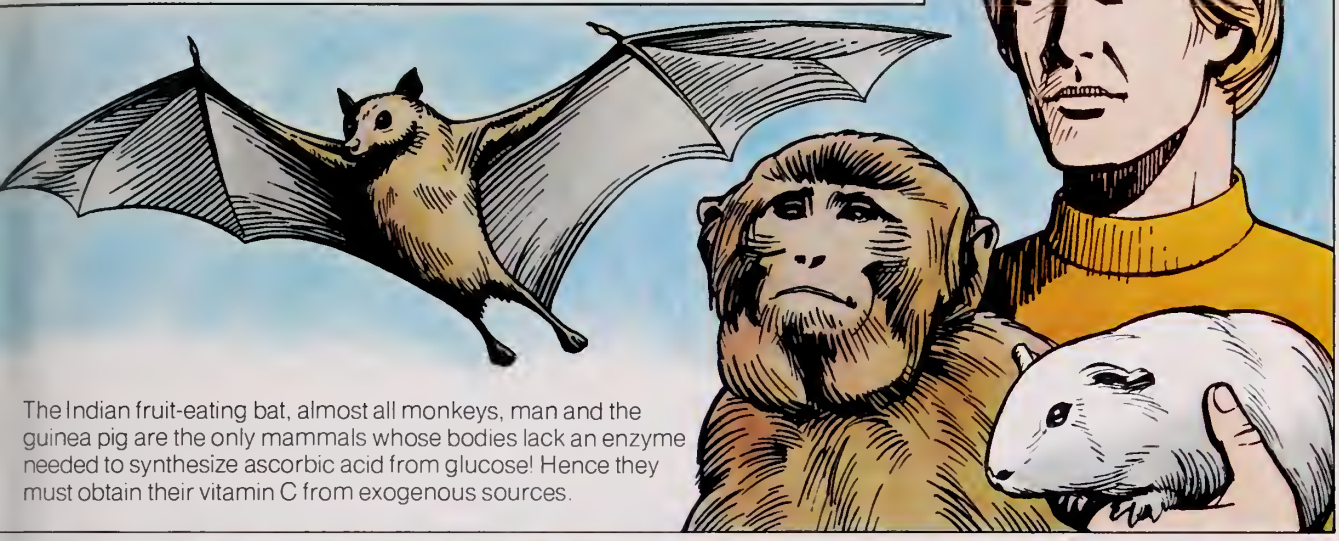
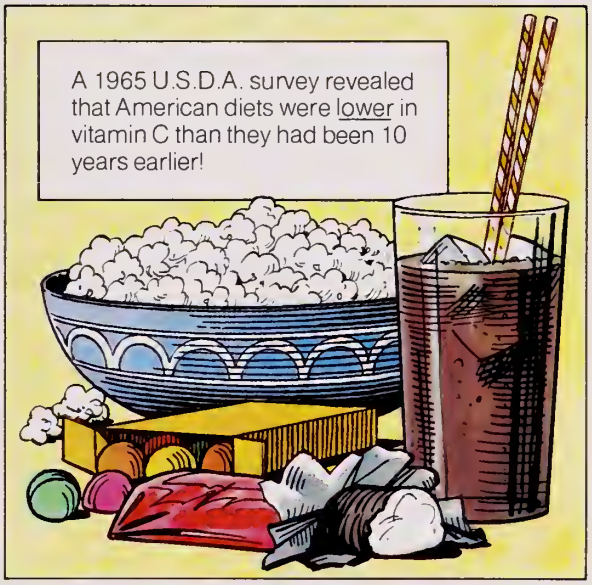


The Indian fruit-eating bat, almost all monkeys, man and the guinea pig are the only mammals whose bodies lack an enzyme needed to synthesize ascorbic acid from glucose! Hence they must obtain their vitamin C from exogenous sources.

De Joinville writing about a 13th century crusade reported that barber surgeons had to "cut away the dead flesh from the gums to enable people to masticate their food." The disease he described was probably scurvy.



The outer leaves of cabbage and brussels sprouts contain more vitamin C than the heads. Yet, ironically, these are often trimmed away by the grocer to improve appearance and enhance sales appeal! Many housewives trim them even more before cooking!

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phenobarbital	(¼ gr.) 16.2 mg	(½ gr.) 32.4 mg	(¾ gr.) 48.6 mg.
(warning: may be habit forming)			

Brief summary. Adverse Reactions: Blurring of vision, dry mouth difficult urination, and flushing or dryness of the skin may occur or higher dosage levels, rarely on usual dosage. Contraindications Glaucoma; renal or hepatic disease; obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); o hypersensitivity to any of the ingredients.

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What's on your patient's face...

may be more important than his chief complaint

Patient P.T.* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.

Patient P.T.* seen on 6/12/67, seven weeks after discontinuation of 5% FU cream. Reaction has subsided. Residual scarring not seen except that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J

The lesions on his face are solar/actinic— so-called "senile" keratoses... and they may be premalignant.

Solar, actinic or senile keratoses

These lesions may be called by several names, but they usually can be identified by the following characteristics. The typical lesion is flat or slightly elevated, of a brownish or reddish color, papular, dry, rough, adherent and sharply defined. They commonly occur as multiple lesions, chiefly on the exposed portions of the skin.

Sequence of therapy— selectivity of response

After several days of therapy with Efudex® (fluorouracil), erythema may begin to appear in the area of the lesions; this reaction usually reaches its height of unsightliness and discomfort within two weeks, declining after discontinuation of therapy. This reaction occurs in affected areas. Since the response is so predictable, lesions that do not respond should be biopsied.

Acceptable results

Treatment with Efudex provides highly favorable cosmetic results. Incidence of scarring is low. This is particularly important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

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This patient's lesions were resolved with

Efudex®

fluorouracil/Roche®

5% cream/solution...a Roche exclusive

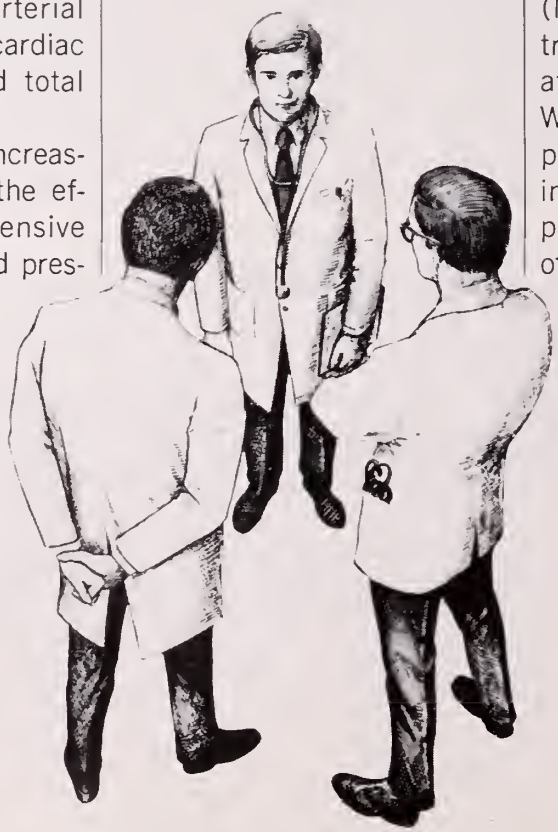
The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

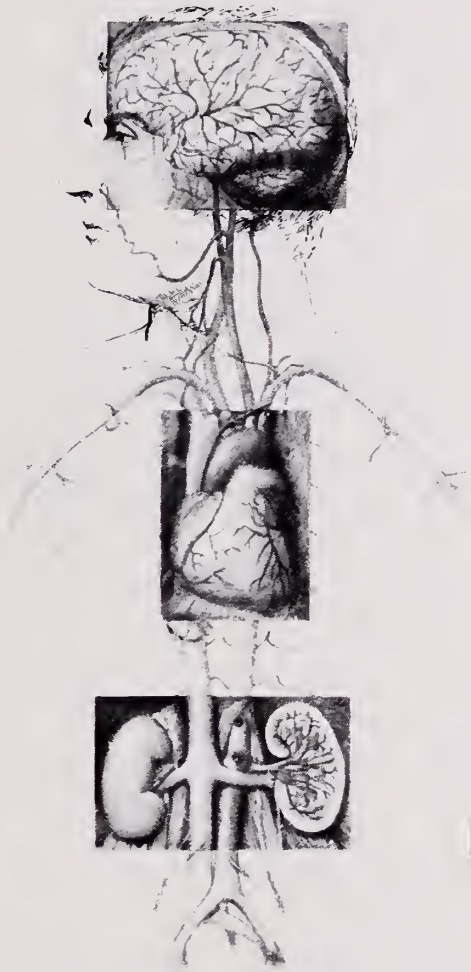
And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?

With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in



the more physicians rely on this unique antihypertensive



lowering blood pressure. But there are other considerations as well. Cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is actually slowed. Peripheral resistance is apparently reduced. ALDOMET does not usually compromise existing renal function; it generally does not reduce renal blood flow, glomerular filtration rate, or filtration fraction. And ALDOMET usually does not cause symptomatic postural or exercise hypotension.

Contraindications include active hepatic disease and known sensitivity to the drug. Use with caution in patients with a history of liver disease or dysfunction. Not recommended in pheochromocytoma or pregnancy.

It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

In most cases of sustained moderate hypertension

TABLETS, 250 mg and 500 mg

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(METHYLDOPA | MSD)

smoothly lowers blood pressure

NEW now available in **500 mg TABLETS** as well as the standard 250-mg tablets

For a brief summary of prescribing information, please see following page.

In most cases of sustained moderate hypertension

ALDOMET® (METHYLDOPA MSD)

smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis. Known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between six and twelve months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at six and twelve months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first six to twelve weeks of therapy or whenever an unexplained fever occurs. If fever, abnormalities in liver function tests, or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur.

Use in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Methyldopa may interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure are occasionally seen and include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Angina pectoris may be aggravated. Symptoms of orthostatic hypotension may occur; if symptoms occur, reduction of dosage is suggested. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distention, constipation, flatus, and diarrhea occur occasionally; these generally can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently and are relieved by administering a thiazide diuretic; if edema progresses or signs of pulmonary congestion appear, discontinue drug. A rise in BUN has been observed. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, Bell's palsy, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Note: Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Maximal recommended daily dose is 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

How Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

addendum

MSD MERCK SHARP & DOHME

"Required Reading" For Your Hypertensive Patients

Because of the importance of patient motivation, Merck Sharp & Dohme offers "High Blood Pressure," a concise, pocket-sized booklet that defines the patient's own role in the management of hypertension. This booklet is available for you to give to your patients. It is designed to reinforce your explanation of hypertension and it emphasizes the importance of patient understanding in adhering to the regimen you prescribe.

Please ask your Merck Sharp & Dohme Professional Representative or write Professional Service Department, West Point, Pa. 19486 for a supply of this booklet.

National cancer act

The House and Senate have agreed to the conference report on S. 2893, the National Cancer Act Amendments of 1974 which authorizes a three year extension of the National Cancer Program. Included in the bill is the establishment of a President's Biomedical Research Panel. The seven member panel would make recommendations to the President and the Congress on policy issues concerning the organization and operation of biomedical and behavioral research conducted and supported under the programs of the National Institute's of Health and the National Institute of Mental Health.

Military pay act

The House Committee on Armed Services has reported H.R. 15936 which would provide for continuation pay for physicians of the uniformed services who are in their initial residency period. The bill would modify the recently enacted Military Special Pay Act which excludes officers in initial residency from receiving incentive bonuses and requires 5 years of service as a condition for special bonus pay. The pending bill would provide that medical officers who have completed their 5 years of service, but who have for one reason or another not yet begun their initial residency program, would be eligible for their special bonus pay during their initial residency.

OCTOBER IS

IAM

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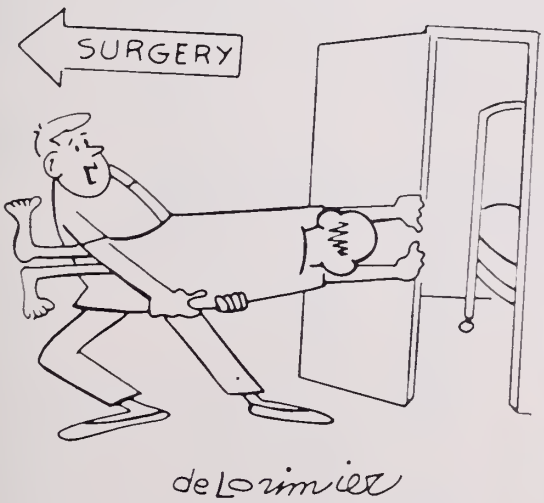
Appropriations

The AMA called for increased funding for several critical health programs. The Committee is presently considering H.R. 15580, the Labor-HEW appropriations bill for fiscal year 1975. Speaking to Maternal and Child Health and Crippled Children's Services, the Association called for full funding of $350 million. In its comments the Association stated "It is widely agreed that the Maternal and Child Health and Crippled Children's Services Programs have been generally successful in providing needed financial assistance and have had an overall beneficial effect on improving the health and well-being of mothers, infants, and young children in many areas of the country. We believe that it is essential that the present programs be adequately funded so as to permit them to continue their contribution to upgrading the health of many of the Nation's disadvantaged mothers and children."

Another program for which the Association urged full funding was the recently enacted emergency medical services system. The AMA said that full funding would be required to fully implement P.L. 93-154, which was characterized as a "promising means by which communities may be assisted in establishing comprehensive community based emergency medical service programs."



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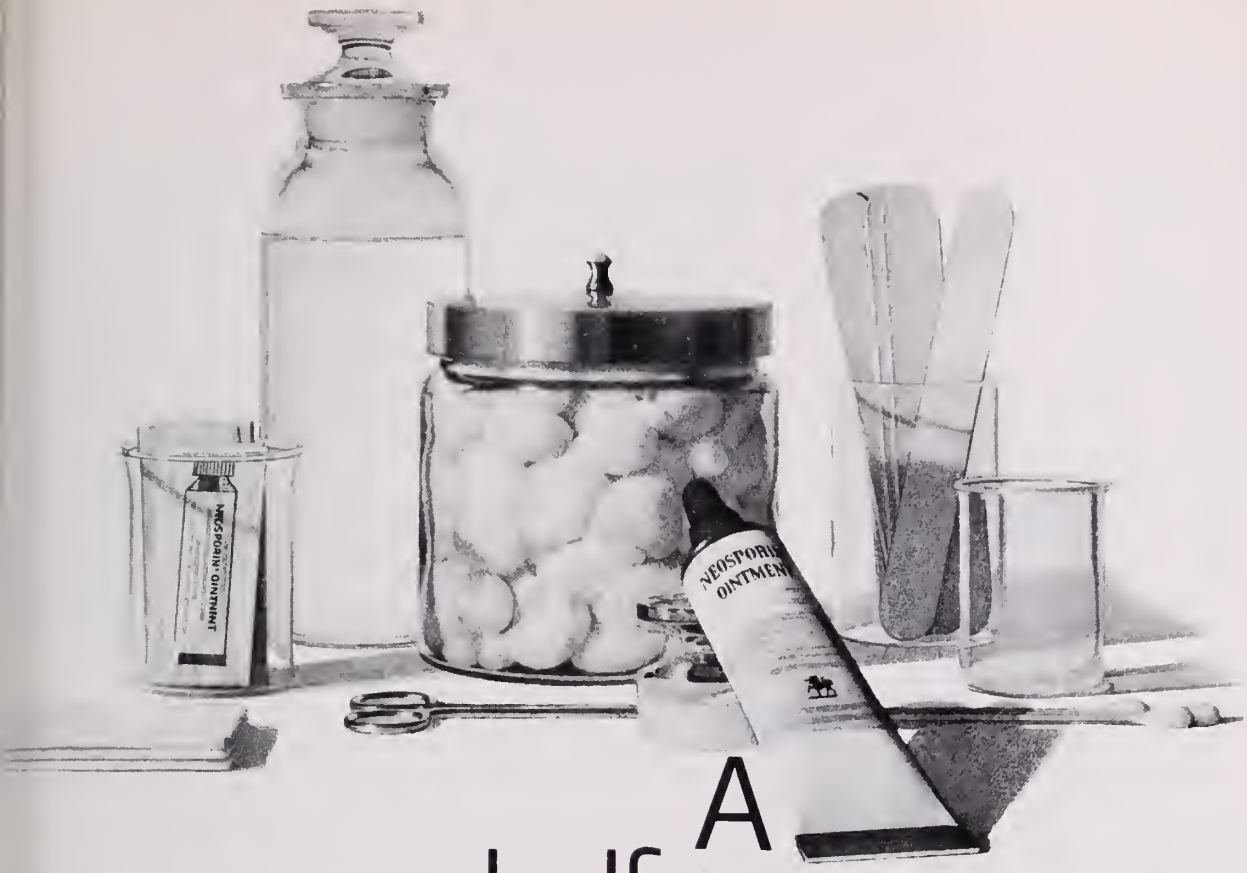

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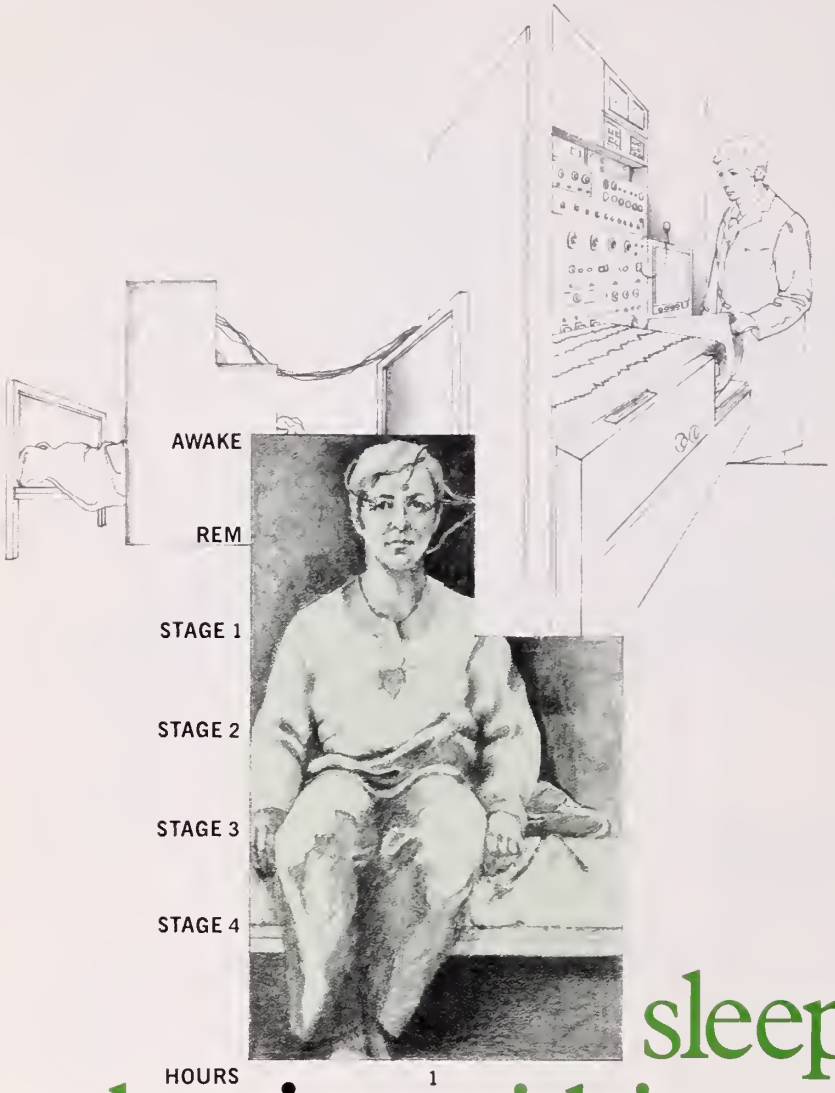

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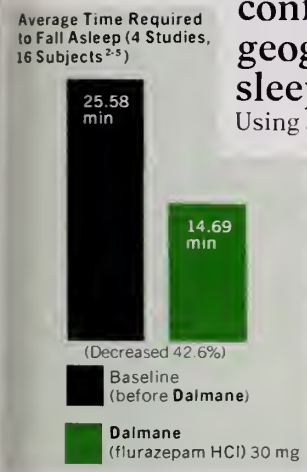
proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

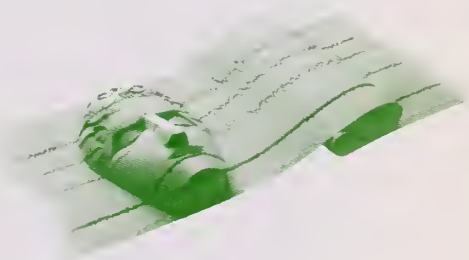
Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage.[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.
Contraindications: Known hypersensitivity to flurazepam HCl.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

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- **reduces nighttime awakenings**
- **sustains sleep 7 to 8 hours, on average, without repeating dosage**

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THE HOSPITAL SMELL

There used to be a strong smell that greeted you when you walked into a hospital, and I will say right here that I think it was iodoform, or it may have been our old friend carbolic acid. Whatever it was, it was there because, in addition to its penetrating and peculiar odor, its other property was antibacterial or disinfectant or germicidal, which are probably all the same.

Now it may have been used because of its strong scent. The message you got when you entered the hospital was antiseptic; the smell was almost overpowering, and it made you feel clean and safe.

But the smell is gone. Hospitals do not reek of iodoform or phenol now. It reminds me of mouthwashes and soaps that owed their popularity to the strong scent that greeted you when you used them. I wonder what happened to all the patients and the hospital personnel who breathed in the disinfectant all day. Of course, if an odor-free substance is used now, we may be still inhaling it without the warning we once had.

I have had occasion to use our public library every day for many days recently, and when I climbed all the way up to the second floor, I was confronted by my old friend the hospital smell. It made me feel clean and safe but in the wrong place, and since there is nothing like smell to take you back over the years, it took me back to my student or even to my childhood days, when I had my tonsils out, I think. And I remember I didn't like it. The tonsillectomy, I mean, not the hospital smell.

—F.C.

DOES MEDICINE HAVE TO TASTE BAD TO BE GOOD?

I remember a medicine I was given my first decade of life. I think it was for a cough, and it tasted like chocolate to which something bitter had been added, so that it was good, but not *too* good. Later, I remember swallowing something that smacked of cherries, but not exactly. I learned in medical school that you can put the active ingredient in almost any diluent or vehicle, but the patient identifies the drug with the color and flavor of what it is contained in, even to the extent of thinking of it as the medicine that comes in the little brown bottle.

But all medicine has a placebo effect which is not to be tossed away. And like poultices and plasters, medicines will make you feel better and they will seem more potent, if they have a strange taste; then you know there is something powerful in what you are taking.

This may be why medicine is better given by needles than by mouth. It hurts, and you know something has been done to you, and you can expect that it will have a powerful effect. Just look at castor oil.

Do big pills make you feel better than little ones? It is possible; and it may also be that green medicine is better for you than red. I think we should tell the pharmacist what color we want the medicine to be and how it should taste. At least, more thought should be given to these things.

—F.C.

DOES THE FIVE YEAR CURE RATE APPLY TO THE PATIENT?

The surgeon and the patient will choose a procedure that has been shown to be followed by a long postoperative life span, generally measured by the five year cure rate. This indicates the number of people who are alive and free of the disease five years after the operation. It is a rough test, it is the only one we have, and it is a good one. It is entirely statistical and is without theoretical consideration; it is a crude yardstick.

But suppose you are the patient; how does this test apply to you? When can you feel that you are free of the disease?

It is like life expectancy tables that tell

you how many, but not who, will be alive at the end of the first year, and the second year, and all the years. If you are alive at ten years, can you conclude that you are cured? No, but the chance that you are rid of the disease is greater than it was at five years.

There is no number of years that will tell you. There are tests for malignancy and there are second look operations, but five year cure rates will not tell the patient when the disease is gone. It will help you to select the operation, and then you are on your own.

But, as is true of life expectancy tables, you keep beating the odds as you continue to survive. If you are alive at five years, you are one of the survivors, but not by much. Suppose the chance of your living ten years is only 20 percent, and you *do* live ten years; does that mean you are cured?

—F.C.

CAN YOU GAIN TWO POUNDS IF YOU EAT ONE?

The calorie theory, according to which calories do count, translates your weight problem into energy things. You take in energy and you use or expend energy, and your weight gain or loss depends on which is bigger; then you change that back into pounds. This becomes mathematical as well as theoretical if not downright conjectural; and anyway, if the theory is right, I should gain weight when I lie in the sun.

But if you *weigh* everything that goes into your body and everything that comes out, you have a new kind of balance, and you don't have to change from calories to pounds and back again.

I have learned to shun things that are loaded with calories or things that put pounds on you, and I have begun to wonder what would happen if I ate just one potato chip, which Bert Lahr said you couldn't do; or one peanut, which everybody says you can't do. Would I gain a pound if I ate a half-pound of butter? Are the calories more important than the pounds? Is there a trigger or a catalytic reaction?

There is a third counting system, in addition to the calorie and the pound theories. Everything you eat can be measured in pleasure units, I think. And the thing to do, if you are not luckily disposed toward skinniness, is to avoid everything you like. You can eat as much of the foods you don't want to eat as you like. Try it; you'll like it.

—F.C.

WHY DO WE GARGLE?

To gargle is to rinse the pharynx and the nasopharynx; or to rinse the mouth and throat. It means to hold liquid in the mouth and throat and agitate it with air from the lungs. Gargling is rinsing the throat with a liquid agitated by air from the treachea and so prevented from passing through the esophagus.

I do not know why putting a liquid in the mouth is good for you, aside from your feeling that you are doing something. I cannot think that it accomplishes anything, and there is always the danger of your swallowing something you wish you had not swallowed.

But if you must put a not-to-be-swallowed fluid in your mouth for medicinal purposes, why breathe through it? This is even sillier than just putting the stuff in your mouth. But again, there is the thought that you are doing something, because you are doing more than just holding the elixir in your mouth; and there is of course the wonderful jangling noise you make when you gargle.

All of this may really be irritating to a throat that wants soothing, but we feel what we are doing and we cannot resist thinking of the lovely sound we make and somehow know that it is good for us.

—F.C.

SCANS AND BLOTS

Brain and liver scans look like blots of ink to me, and I wonder if they do not seem so to others. So I have come up with this wonderful idea. A brain scan can serve two functions; it can be read by

a bran scan specialist, and it can be shown to the patient for his own interpretation. For if brain scan is done, there is evidence of mental disease, whereupon a sort of Rorschach test is in order; any ink blot will do.

If the patient is to be seen by a gastroenterologist and by a psychiatrist, a liver scan can be used in place of the customary ink blot. There is no end to this.

I suggest that the patient be allowed to see his scans, and be encouraged to tell us what he sees. It can't hurt.

—F.C.

TIME AND SPACE

The difference between time and space is simple. If you knew *where* you were going to die, you might see to it that you never went near the place. But if you knew *when* you were going to die, you could not avoid going through the time of your death.

—F.C.

ON CONFIDENTIALITY

The relationship between the patient and the doctor is strange and, for all its being likened to what goes on with priest and attorney, it is unique. When the adult comes, of his own volition, to the physician whom he has himself chosen, what the doctor is told and what he discovers are a matter of confidence.

But if the M.D. learns that his patient harbors a disease that endangers others, must the confidence be kept? If the patient has been wounded, is an exception to be made? If the patient is a child, are the parents to be told? If a teenage is pregnant or has a venereal disease, should someone be informed?

I should like particularly to know what the relationship becomes when the patient is sent by his employer for a routine examination. Does the doctor tell everything to the patient, or to the company for whom the patient works, or to the firm by whom the physician is employed?

How sacred is the patient-doctor relationship in these cases? If the patient is not conscious, do we draw blood to be examined for alcohol, if the police want us to? If we stop at the scene of an accident, have we established a patient-doctor relationship in its full meaning?

I believe the relationship between the patient and the doctor should exist when our help is sought by the patient, in any case; and if the clergy and the law mimic our efforts, we can feel proud. But the trust was always ours, and we keep it, even now.

—F.C.

Aspirin and Anemia in Childhood — H. Heggarty (Frirage Hosp, Northallerton, England). Br Med J 1:491-492 (March 16) 1974.

Five children in whom significant anemia seemed clearly related to chronic aspirin ingestion are reported. Since patients and parents do not consider aspirin as a drug, specific questioning about aspirin ingestion should be included in history-taking in such cases. Aspirin is overly prescribed and too easily available without prescription. This paper stresses that chronic aspirin ingestion in childhood is not uncommon, often goes undetected, and bay cause serious anemia.

Facing Air Passengers' Medical Problems While on Board — R. Iglesias et al (Service of Professional Diseases, National Medical Center, Mexico). Aerosp Med 45:204-206 (Feb) 1974.

Airplane travel in general does not appreciably affect the physiology of the healthy individual, but in certain patients the slight hypoxia of the cabin, the changes of barometric pressure, the motional stress of the trip, the crossing of turbulent zones, the arrival in high-altitude cities can lead to the worsening of previous medical problems. Suggestions are presented for adequate management of medical problems occurring in flight.

Perinatal Mortality and Maternal and Infant Care Program at the University Of Nebraska Medical Center

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THE Maternal and Infant Care Project (MIC) is a federally sponsored program, functional at the local level. It is designed to offer prenatal care to the indigent and out-of-wedlock pregnant patient. This segment of society exists in all sizes of communities, varying only in numbers, and is marked as the main contributor to increased prematurity, perinatal mortality and maternal complication rates.

The impact of this program, which was instituted July 1965, is shown in Figure #1. The 1970 Nebraska State perinatal mortality rate was 25.8 per 1,000 total births. When broken down by counties, it ranges from 0.0 to 53.3. The U.S. 1970 rate was 19.0.

At the present time MIC reaches out to the indigent of defined census tracts in Douglas County. Out-of-wedlock pregnancies may take advantage of this program without the residential restriction. In 1971, 53% of Nebraska counties had out-of-wedlocks who were served by this program.

Success in dealing with perinatal mortality problems means fighting failure rates; failure to come in early in the pregnancy, failure to keep appointments, to follow advice, etc. The incidence of unregistered patients at the University of Nebraska Medical Center is 5.3%. Only coordinated efforts by paramedical and medical personnel can hope to motivate this patient.

Smaller communities may recognize these segments as patient, office nurse, and doctor acting as both obstetrician and pediatrician. Larger communities have patient, paramedical (nurse, nutritionist, social worker, medical technologist, community worker), and medical (obstetrician, pediatrician, and dentist).

Whether simple or complex, the basic pattern of patient care and education is the same. Adequate prenatal care is necessary if the perinatal mortality, prematurity, low birth weight babies, deformities, and maternal complication rates are to be lowered.

Prenatal care today has become more sophisticated. Medical and dental education is as important as the care itself. Nutritional and social advice are a part of the program. Available also are methods to determine fetal age and growth, as well as placental localization and monitoring devices for fetal heart beat status. Added to the routine laboratory work of CBC, urinalysis, chest x-ray and serology, are blood typing and Rh status, routine cultures for GC (at least on two occasions), and often urine cultures. Hemagglutination inhibition (HI tests) for rubella are included. For blacks, glucose-6-phosphate dehydrogenase (G6PD) and sickle cell testing are added.

Amniocentesis is becoming an important part of the prenatal care. Testing of the amniotic fluid gives us added insight into the fetal well being and helps guide the course for care in complicated cases.

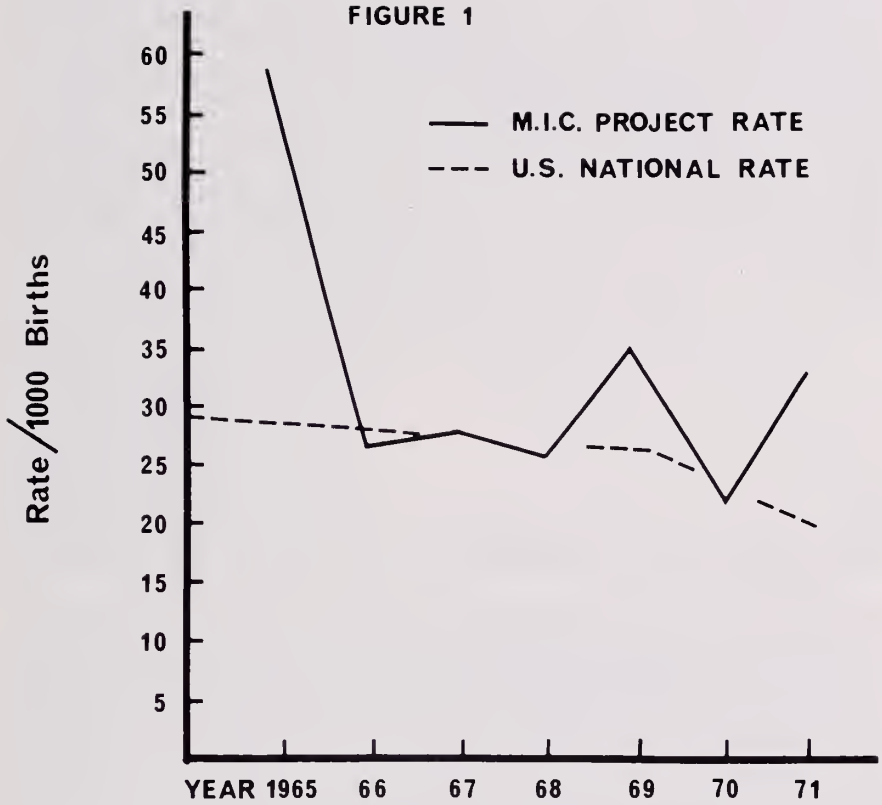
Modern day neonatologists are an integral part of the team concept. A recent article by VanLeeuwen, G. and Miyazaki, Y. clearly defines the problem and points out their importance in helping bring down the level of perinatal mortality.[1]

Whether public or private, it is still the doctor's obligation to coordinate these efforts.

Reference

1. VanLeeuwen G, Miyazaki Y: Problems of the newborn infant. Nebraska M J, p 321, August, 1972.

FIGURE 1



PERINATAL MORTALITY: Include stillborn or liveborn who die within 28 days after birth whose weight is 500 gms. or more or if less than 500 gms. show signs of life at birth.

Left Ventricular Intracavitary Mass—An Unusual Case

ABSTRACT

The authors present the case of a man who at catheterization was demonstrated to manifest a smooth, round, nonmobile mass in the apex of the left ventricle as seen in the right anterior oblique projection. This mass was not visualized in the left anterior oblique projection. Selective coronary arteriographic studies were normal. Histologic study of the mass revealed it to be a fresh and organizing thrombus.

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WELL defined left ventricular intracavitary masses as demonstrated angiographically are rare. The angiographic differentiation of tumor and thrombus is frequently difficult due to an insufficient number of reported cases describing the angiographic findings. It has been reported that, angiographically, a tumor is a lobulated, possibly mobile mass with irregular, rounded edges whereas a large thrombus will produce a much more irregular defect which is less well defined and immobile.[1, 2] This communication reports the unusual angiographic picture, as well as the clinical, surgical and pathological findings of a left ventricular thrombus.

Case Report

A 41 year old man was admitted to the hospital for evaluation of recurrent chest pain of six months duration. He had been well until January 1972, when he suffered an anterior myocardial infarction which was documented enzymatically and electrocardiographically. Following recovery, he suffered intermittment, diffuse, anterior chest pain with radiation to the left arm. The dur-

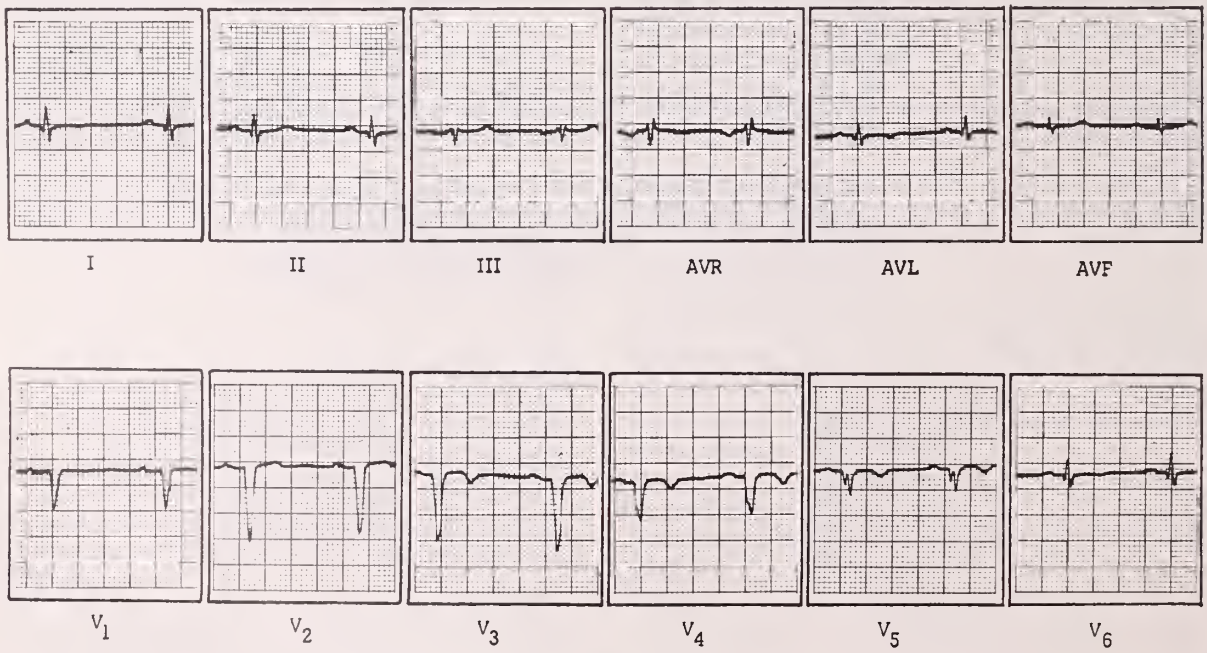

Figure 1. The resting electrocardiogram reveals an old anterior myocardial infarction.

ation of pain would range from minutes to many hours, and was not definitely related to specific temporal events. It was not relieved by nitroglycerine. The patient also described brief episodes of vertigo associated with diplopia.

Physical examination revealed a well developed man in no distress. Blood pressure, pulse, cardiorespiratory and neurologic examinations were within normal limits.

Routine laboratory examinations including serum cholesterol, triglycerides, and lipoprotein electrophoresis were within normal limits. A routine electrocardiogram (Figure 1) revealed an old

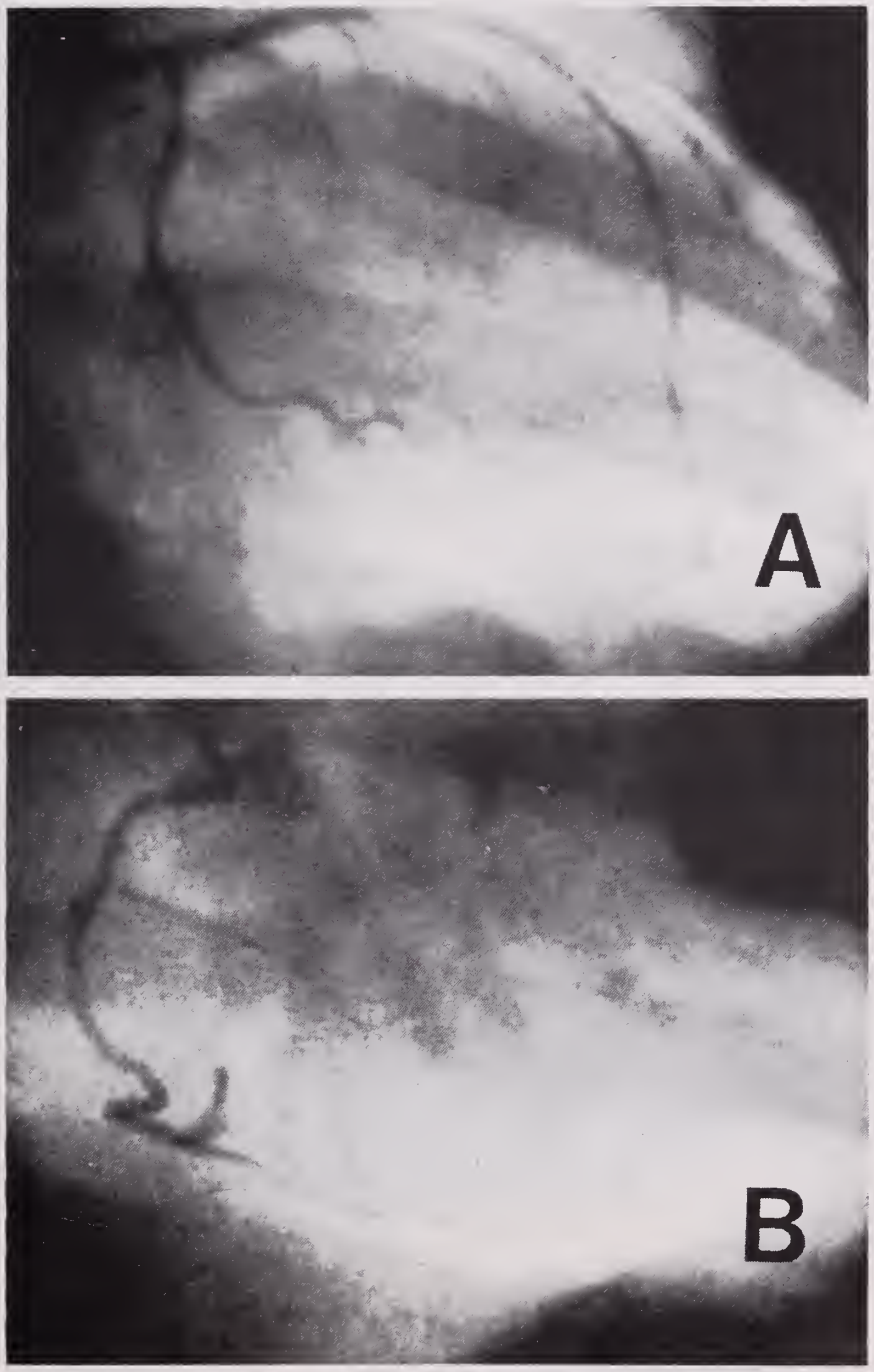

Figure 2, A and B. A—The left coronary artery, right anterior oblique view reveals no lesion. B—The right coronary artery, right anterior oblique view reveals no significant occlusive lesion.

anterior myocardial infarction. A graded exercise test failed to reveal any ischemic ST-T wave changes.

Cardiac catheterization studies revealed normal right and left heart pressures. Selective coronary angiography (Figure 2) revealed no significant occlusive coronary artery disease. Left ventriculography was performed with the patient positioned at 30 degrees of right anterior obliquity and 60 degrees of left anterior obliquity. In the right anterior oblique projection a smooth, round, nonmobile mass was well visualized. (Figure 3). There was anteroseptal and apical akinesis. The intracavitary mass was not definitely delineated in the left anterior oblique projection.

At surgery, left ventriculotomy was performed under total cardiopulmonary bypass. The apex of the left ventricle was thin and fibrotic. A smooth, round thrombus measuring 2.5 cm was closely adherent to the apical septum. A small, smooth, round, 1cm diameter thrombus was supported by a short pedicle arising from the larger nonpedunculated thrombus. Palpation of the right and left coronary arteries failed to reveal evidence of atherosclerosis.

Histological study of the thrombus revealed both fresh and organizing thrombus[3] (Figure 4).

Discussion

The angiographic differentiation of left ventricular tumor and thrombus is difficult. This fact is substantiated by our report. One might expect a pedunculated thrombus to be mobile. In this case cinecardiography failed to suggest this possibility. The importance of multiple views to demonstrate a left ventricular thrombus is suggested by nonvisualization of the thrombus in the left anterior oblique projection. Myocardial infarctions have been reported in the absence of significant coronary artery disease.[4, 5] This is such a case. It confirms the fact that normal coronary arteriography, in a specific case, is not per se, useful in differentiating tumor and left ventricular thrombus.

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Figure 3. Left ventriculography, diastole, right anterior oblique view reveals a smooth, round, apical mass.

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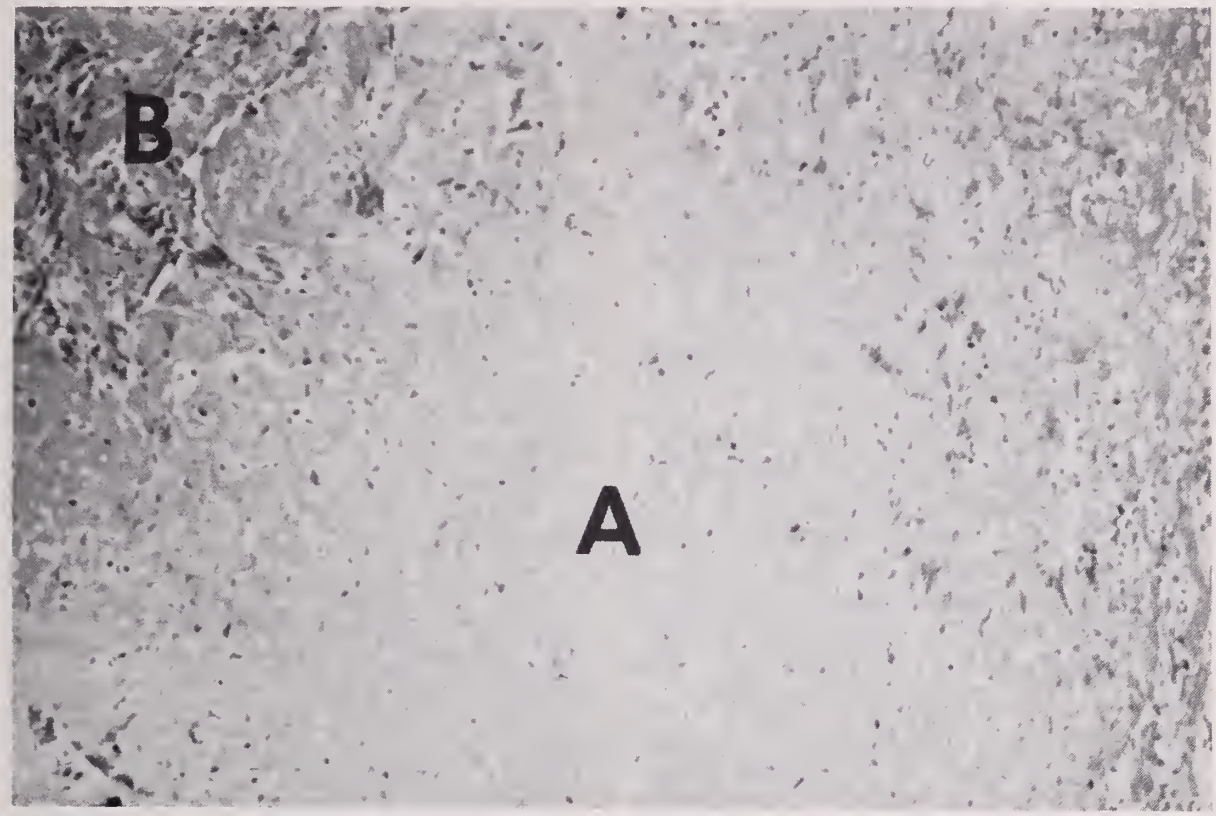

Figure 4. Left ventricular mass reveals fresh (a) and organizing (b) thrombus. (Hematoxylin and Eosin stain: x 100.)

Vitamin C and Serum Cholesterol Levels in Humans

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Introduction

GINTER (1973) has found that a chronic vitamin C deficiency in guinea pigs leads to elevated serum cholesterol levels.[4] Ginter (1972) has also shown the existence of a linear correlation between vitamin C concentration in the hepatic tissue and cholesterol-26-(^{14}C)-oxidation.[3] This has prompted the hypothesis that vitamin C may reduce serum cholesterol by promoting the hydroxylation of cholesterol to bile acids.[5]

We are aware of only three studies, involving humans, wherein the effect of vitamin C ingestion upon serum cholesterol levels has been evaluated. Spittle found an 8 percent reduction in serum cholesterol levels among healthy human subjects, less than 25 years of age, when given 1 g per day dietary vitamin C supplements.[8] She found no effect of vitamin C upon serum cholesterol levels in normal subjects above 25 years of age, but she reported an 8 percent *increase* in the levels of serum cholesterol in artherosclerotic patients. Anderson et al reported that in a double-blind assessment of vitamin C and the common cold, the mean serum cholesterol level of the vitamin C group (ages 18-24) was no lower than a group receiving placebo tablets after 14 weeks of the study.[1] There also was no rise in serum cholesterol levels following discontinuation of vitamin C intake.

Ginter et al (1970) administered 300 mg daily doses of ascorbic acid to persons who met two criteria: (1) low vitamin C blood levels (less than 0.6 mg%); and (2) high serum cholesterol levels (232-312 mg%).[6] These investigators found a significant reduction in serum cholesterol after 47 days, a reduction not shown in the control group.

The present study employed a double-blind procedure, to evaluate the capacity of extra-dietary vitamin C doses to reduce serum cholesterol levels in healthy human subjects. Any differential effects due to age or gender were also explored.

Methods

Subjects

Forty-two employees of the University of Nebraska Medical Center who volunteered were used as subjects. Eleven withdrew during the first two weeks.

Initially, subjects were grouped according to sex and age, with the 36th birthday arbitrarily chosen to divide the older from the younger subjects. Half of the subjects received vitamin C capsules while the others were given placebo for a period of six weeks.

Blood Samples

Blood samples were taken from all subjects between 9 a.m. and 11 a.m. Subjects were asked to consume nothing after the preceding evening meal save for a light breakfast of toast and juice. This was repeated every two weeks. In all, four samples were taken from each subject: the intial basal sample and three later samples (at 2, 4, and 6 weeks). Serum cholesterol levels were determined using the Levine-Burchard method.[2]

Experimental and Placebo Medications

Each subject, following the initial blood sampling, was given a bottle of 84 capsules with instructions to take two each day at breakfast. Half of the bottles contained 500 mg capsules of vitamin C, while the other

contained a placebo of identical appearance. Investigators as well as the subjects were "blind" as to which patients received vitamin C and which received placebo.

Subjects were asked not to make any major changes in their habits during the course of the study, and no restrictions, including dietary and activity level, were placed upon them.

Results

Attrition resulted both in small groups and in inequality of group sizes. Statistical comparisons of the groups were therefore made using the Fisher exact probability test.[7] Table 1 presents the number of subjects who showed decreased or increased cholesterol levels compared to their basal readings at two, four, and six weeks. As shown, none of the differences between the two groups reached the 0.05 level of significance. The differences between the groups at the four and six week marks approached significance in the predicted direction.

The same method was used to compare males with females, and younger with older subjects. No differences in serum cholesterol level change were found.

Even though the changes in serum cholesterol level approached statistical significance, the results do not appear to be important clinically. Eighty-nine percent of the final two serum cholesterol readings for the ascorbic acid group were either above, or less than ten percent below, the basal levels.

Discussion

The hypothesis that dietary supplements of vitamin C lower human serum cholesterol was not supported at a statistically or clinically significant level by this study. The tendency of the data to fall in line with the hypothesis, while not reaching significance, suggests the possibility that by administering vitamin C in larger doses or by more closely controlling dietary factors, a significant biological and/or clinical change may be observed. Dietary control, such as that enforceable with inmate populations, could reduce the possibility that chance dietary differences among the groups tended to obscure differences otherwise attributable to vitamin C.

The failure to confirm the hypothesis suggests that, in healthy adults with presumably adequate dietary intake of vitamin C, supplementary doses of vitamin C does not add to the body's ability to remove cholesterol from the circulatory system. Ginter et al in 1970, indicates that vitamin C in the diet is necessary to maintain normal serum cholesterol levels.[6] This investigation does not support the assumption that vitamin C is an effective cholesterol-control agent for persons not suffering from a dietary deficiency. The organism may use enough ascorbic acid to maintain cholesterol levels in the individual's normal range. Additional vitamin C, it appears, may not be used beyond the individual's normal basal level.

Table 1

	TWO WEEKS		FOUR WEEKS		SIX WEEKS	
	Lower	Higher	Lower	Higher	Lower	Higher
Vitamin C	11	5	13	1	12	5
Placebo	9	7	8	5	6	8
p values	ns		0.071		0.119	

Number of subjects who showed lower-than-basal or higher-than-basal serum cholesterol levels on subsequent tests.

Summary

The suggestion that vitamin C (ascorbic acid) may promote the hydroxylation of cholesterol to bile acids, thus lowering serum cholesterol levels, was given a clinical test with human subjects.[5] Thirty-one normal adult volunteers participated in a double-blind experimental procedure. Seventeen were given daily dietary supplements of one gram vitamin C for six weeks. Fourteen received placebo. The results were in the predicted direction, but did not reach statistical or clinical significance. Some suggestions for further clinical research are presented.

ACKNOWLEDGMENTS

James Dube, R.P., for his work in randomly assigning subjects and in preparing and distributing the capsules.

Fred D. Strider, Ph.D., for his statistical consultation.

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Diagnosis of Trichinosis

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FOR the past several years, nearly one hundred or more cases of trichinosis have been reported annually and have been associated with occasional deaths. The diagnosis of trichinosis is not always straight-forward, and the disease may involve many different organs and present a confusing array of signs and symptoms. Therefore, we felt that the following outline for the diagnosis of trichinosis would be of value.

I. History
   A. Ingestion of incompletely cooked or improperly prepared
      1. Pork products
      2. Bear meat
      3. Beef products adulterated with pork
   B. Simultaneous involvement of more than one person — usually

II. Parasitology
   A. Trichinella Spiralis — a tissue inhabiting nematode that is without an immediate host
   B. Three phases of the disease
      1. Gastrointestinal or invasive
         a. This follows the ingestion of meat containing encysted larvae
         b. The cyst is digested in the stomach and the larvae migrate to the small intestine which they invade
         c. Following maturation and copulation, the female trichina deposits larvae into the wall of the small intestine
         d. During this phase, gastroenteritis — usually during first 48 hours
      2. Migratory phase — begins as larvae enter the venous circulation and are disseminated systemically
      3. Encystment phase — the mature larvae encapsulate and survive only in skeletal muscle

III. Clinical
   A. Fever — begins with muscle invasion and peaks 7 days later
   B. Head
      1. Conjunctivitis
      2. Periorbital and facial edema
      3. Parotid and sublingual glands swollen and tender
   C. Cardiovascular
      1. Myocarditis
         a. Accounts for most fatal cases
         b. Occurs after the third week (fourth to eighth week)
      2. Congestive heart failure
      3. Vascular thrombosis

4. Pulmonary emboli
5. Subungual hemorrhages
6. Retrosternal pain
7. Hypotension

D. Respiratory
1. Dyspnea
2. Cough
3. Pleuritis
4. Hoarseness
5. Bronchitis
6. Bronchopneumonia
7. Pulmonary emboli

E. Gastrointestinal
1. Diarrhea and/or constipation
2. Pains
3. Hepatomegaly and possibly splenomegaly

F. Genitourinary
1. Myoglobinuria (rare) during fourth to fifth week
2. Oliguria

G. Skin
1. Macular or maculopapular rash
2. Pruritis
3. Subungual "splinter" hemorrhages
4. Diaphoresis

H. Lymphatic — Lymphadenopathy

I. Neurologic
1. Signs and symptoms
   a. May be upper or lower motor neuron
   b. Includes 10-24% of all classical cases
   c. May start before end of second week
2. 8-46% of these cases are fatal
3. Meningitis
4. Encephalitis
   a. Diffuse symptoms — appear during larval migration (second week) and are manifested by a decreased level of consciousness, seizures, and/or psychosis
   b. Focal symptoms — appear during encystment (during and after third week) and are manifested by —paresis, —plegia, ataxia, aphasia, seizures
5. Cranial nerve involvement
   a. VI
   b. VII
   c. nystagmus
6. Cerebellar signs — especially ataxia
7. Radiculitis
8. Peripheral neuropathies — either mono- or poly-
9. Muscular — the myositis may persist for months and be of such intensity as to produce
   a. difficulty chewing
   b. dysphagia
   c. trismus
   d. dyspnea
   e. flaccid paresis
   f. diplopia
   g. or it may stimulate meningitis

IV. Laboratory

A. Eosinophilia
1. With leukocytosis
2. 85% of cases by end of second week
3. Poor often fatal prognosis associated with a low or a sudden drop in the eosinophil count

B. Erythrocyte sedimentation rate (ESR) is relatively low in face of severe inflammatory disease

C. Intradermal trichinella skin test

D. Bentonite flocculation test

E. Latex trichina reagent rapid slide agglutination test

F. Muscle biopsy

G. Abnormal liver function tests

H. Electrocardiogram — abnormal in 19.4-33% of cases
   1. Most frequent — flattening or inversion of T wave in leads I and II
   2. Frequent changes
      a. low amplitude QRS complex
      b. atrioventricular or intraventricular block or conduction disturbance
   3. Less frequent
      a. depression of ST segment
      b. sinus arrest
      c. pattern of infarction
      d. bigeminal rhythm
      e. premature ventricular contraction

I. Larvae may be recovered from
   1. Blood
   2. Stool
   3. Sputum
   4. CSF
   5. Meat source

J. Lumbar puncture and cerebrospinal fluid
   1. 50% of cases are normal
   2. 28% of cases reveal larvae
   3. Other findings — variable pleocytosis, xnathochromia, many red cells, elevated pressure, increased protein, first and mid-zone colloidal gold curves, slight increase in albumin and globulin, and a slight increase or decrease in sugar

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Histological Changes in Liver Biopsies Obtained at the Time of Intestinal Bypass Procedures for Morbid Obesity*

Summary

Hepatic dysfunction has been reported as a complication of intestinal bypass for morbid obesity. We have reviewed the hepatic histology in 153 liver biopsies in patients having jejunocolic bypasses, jejunoileal bypasses, revisions, or reanastomoses. Fatty metamorphosis was found in 76% of the livers biopsied at the primary bypass procedure. In addition, inflammation, fibrosis, and fatty metamorphosis appear to be more common following jejunocolic bypass. Liver biopsy appears to represent an essential part of the prebypass evaluation.

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Introduction

INTESTINAL bypass procedures for the treatment of obesity are controversial. Successful weight reduction occurs in the majority of patients, but metabolic and nutritional deficiencies often complicate the postoperative period.[7, 11] Hepatic function and histology are frequently abnormal.[4, 14] Cirrhosis has been described.[3] Postoperative deaths from hepatic failure have been reported.[5] However, fatty metamorphosis,[1-3, 5-8, 10, 11-13] hepatitis, and granulomata[2] have been associated with obesity alone, as well as with obesity treated by intestinal bypass.[9, 13, 15] Preoperative evaluation of hepatic function and histology is important in these patients in order to properly assess hepatic abnormalities which may seem to arise during the postoperative period. However, the prognostic implications of an abnormal liver biopsy before bypass have not been determined.

This study reviews 153 liver biopsies performed on obese patients undergoing intestinal bypass operations for obesity or for complications of previous bypass procedures.

Methods

Wedge biopsies from the leading edge of the right lobe of the liver, were taken by one of us (S.S.) at the time of the primary shunting procedure and/or at the time of revision or reanastomosis of the shunt. All biopsies were examined independently by two of us (J.S. and B.K.) The degree of fatty change, the degree and location of inflammation, and the presence of fibrosis were determined. Conflicting histologic opinions were infrequent and were resolved easily after a microscopic review. Results were tabulated. Staining by the hematoxylin-eosin and Gomori techniques were done on all biopsies. The rhodamine method for staining tissue copper was done on the majority of specimens including all biopsies showing fibrosis and/or granulomata. Special stains for acid-fast bacteria and fungi were done where indicated. Histologic grading of the fatty metamorphosis was performed as previously described.[9] Inflammatory infiltrates in these biopsies were compared to inflammatory infiltrates in similar

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biopsies from nonobese patients not undergoing intestinal bypass. Mild portal inflammation did not distend or disrupt the limiting hepatic plates. Mild parenchymal inflammation was unassociated with fibrosis or hepatocytic destruction. Granulomata had no specific portal or central orientation. When collagenous tissue was increased, but did not meet the criteria for cirrhosis, the biopsy was designated as showing fibrosis.

A total of 194 surgical procedures were performed on these 153 patients, who weighed from 203 to 470 pounds. Forty-six had jejunocolic bypasses and 107 had primary jejunoileal bypasses. Twelve patients later underwent reanastomoses of jejunocolostomies, seven had reanastomosis of jejunoileostomies, and 22 had jejunocolostomies revised to jejunoileostomies. One hundred fifty-three liver biopsies were performed. One hundred twelve were taken at the time of the primary shunting procedure of which 16 were jejunocolostomies and 96 were jejunoileostomies. Thirty-eight biopsies were obtained at the time of revision or reanastomosis. Seventeen patients had biopsies taken both during the primary shunt and during the revision or reanastomosis. Three patients had biopsies unassociated with the primary shunt, revision, or reanastomosis..

Results

Fat was found in 76% of biopsies performed at the primary procedure, predominantly in moderate amounts (1+ to 2+). (See Tables I and II). Chronic inflammation was found in most biopsies, primarily a mild amount. (See Table III). The mild portal inflammatory infiltrate found was not significantly different from that seen in liver biopsies from nonobese patients who have had no bypass procedure. Focal acute hepatitis was present in a lesser number of biopsies. (See Table IV). Epithelioid granulomata were present in 8 biopsies, 6 in jejunoileostomy patients, one in a patient who had a jejunojejunostomy following a jejunoileostomy, and one in a followup liver biopsy. (See Table V). Periportal fibrosis was found in 14 cases, 11 were jejunoileostomies, two were revisions of jejunoileostomy to jejunojejunostomy, and one as a postoperative followup biopsy. Significant copper was not observed in any of the biopsies. Seventeen patients had biopsy at the time of primary anastomosis and again at the time of revision or reanastomosis 5 to 51 months later. (See Table VI). Al-

Table 1

GRADE OF FATTY METAMORPHOSIS IN LIVER BIOPSIES OBTAINED DURING INTESTINAL BYPASS OPERATION FOR MORBID OBESITY: PRIMARY PROCEDURE

	0	±	1+	2+	3+	4+*	Total Patients
Jejunocolostomy	4	2	3	1	5	1	16
Jejunoileostomy	23	15	28	13	14	3	96
Total Patients	27	17	31	14	19	4	112

*—Grade of fatty metamorphosis, 0 through 4+.(9)

Table 2

GRADE OF FATTY METAMORPHOSIS IN LIVER BIOPSIES OBTAINED DURING INTESTINAL BYPASS OPERATION FOR MORBID OBESITY: REVISION PROCEDURE

	0	±	1+	2+	3+	4+	Total Patients
Jejunocolostomy to Jejunoileostomy	3	2	9	4	3	1	22
Jejunocolostomy to Jejunojejunostomy	2	0	5	3	1	0	11
Jejunoileostomy to Jejunojejunostomy	1	1	0	0	0	3	5
Total Patients	6	3	14	7	4	4	38*

*—84% of patients have some degree of fatty metamorphosis.

Table 3

CHRONIC INFLAMMATORY INFILTRATION IN LIVER BIOPSIES IN PATIENTS HAVING INTESTINAL BYPASS SURGERY FOR MORBID OBESITY

	PORTAL		PARENCHYMAL	
	Mild	Moderate-Severe	Mild	Moderate-Severe
Jejunocolostomy	13	0	5	0
Jejunoileostomy	76	16	64	11
Jejunocolostomy to Jejunoileostomy	15	5	12	2
Jejunocolostomy to Jejunojejunostomy	9	0	4	0
Jejunoileostomy to Jejunojejunostomy	3	1	4	0
Biopsy Only	1	0	2	2
Total Patients	117	22	91	15

though the number of patients involved is small, the tendency was to have the histologic changes increased in the followup biopsy. The inflammatory infiltrate did not improve in any of the biopsies and became worse in four patients with primary jejunocolostomy and two patients with primary jejunoileostomy. Of these 6 patients, two had no concomitant change in fat, one decreased and three increased. Three patients developed an increased amount of periportal fibrosis tissue, one following jejunocolostomy and two following jejunoileostomy. Granulomata were present in the second biopsy in one patient who had a jejunocolostomy revised to a jejunoileostomy.

Table 4

ACUTE INFLAMMATORY INFILTRATION IN LIVER BIOPSIES IN PATIENTS HAVING INTESTINAL BYPASS SURGERY FOR MORBID OBESITY

	Portal	Parenchymal
Jejunocolostomy	1	1
Jejunoileostomy	5	6
Jejunocolostomy to Jejunoileostomy	0	1
Jejunocolostomy to Jejunojejunostomy	0	0
Jejunoileostomy Jejunojejunostomy	0	1
Biopsy Only	0	1
Total Patients	6	10

Table 5

MISCELLANEOUS FINDINGS IN LIVER BIOPSIES IN PATIENTS HAVING INTESTINAL BYPASS SURGERY FOR MORBID OBESITY

	Granulomata	Periportal Fibrosis
Jejunocolostomy, Primary	0	0
Jejunoileostomy, Primary	4	11
Jejunocolostomy Revised to Jejunoileostomy	2	0
Jejunocolostomy Revised to Jejunojejunostomy	1	0
Jejunoileostomy Revised to Jejunojejunostomy	0	2
Biopsy Only	1	1
Total Patients	8	14

Discussion

Liver disease, especially fatty metamorphosis, has been reported as a complication of intestinal bypass procedures utilized in the treatment of morbid obesity. Even though obese patients without bypass are known to have an increased incidence of fatty metamorphosis of the liver,[3, 9] in some instances, patients reported to have severe hepatic fatty changes at some time follow-

Table 6

FOLLOWUP LIVER BIOPSIES: CHANGE IN SECOND BIOPSY FROM FIRST BIOPSY

	No Change	Increased	Decreased
	JEJUNOCOLOSTOMY TO JEJUNOILEOSTOMY		
Fat	2	3	4
Inflammation	5	4	0
Fibrosis	8	1	0
Granulomata	8	1	0
	JEJUNOILEOSTOMY TO JEJUNOJEJUNOSTOMY		
Fat	1	3	0
Inflammation	2	2	0
Fibrosis	2	2	0
Granulomata	4	0	0
	JEJUNOCOLOSTOMY TO JEJUNOJEJUNOSTOMY		
Fat	0	1	3
Inflammation	4	0	0
Fibrosis	4	0	0
Granulomata	4	0	0

ing intestinal shunt had not had prior biopsy.[1,4,12] For this reason, the assessment of hepatic function (not herein reported) and histology at the time of the primary anastomosis seems appropriate as a baseline to help evaluate subsequent changes. Seventy-six percent of the liver biopsies done at the time of the primary shunt had some degree of fatty metamorphosis. The distribution is similar between those undergoing jejunocolostomy and jejunoileostomy bypass procedures.

Although our series of patients is small, there appears to develop a greater increase in fat, inflammation, and fibrosis following jejunocolostomy than following jejunoileostomies. Statistically, followup histological changes are difficult to compare with the earlier ones because, in this small group of patients, reanastomoses and/or revisions were usually performed because of some clinical complication. The significance of granulomata is not apparent from this study.

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Chronic Pericardial Effusion and Autoimmune Antibodies – A Case Report

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and
M. CHRISTIANSEN, M.D.

PART I

Introduction

AN occasional patient is discovered to have a massive pericardial effusion with little symptomatology. The assumption is made that a gradual accumulation of pericardial fluid produces sufficient stretching of the parietal pericardium to minimize cardiac restriction. Then, when pericardial fluid accumulates slowly (a few days or a week longer) distention and dilatation of the pericardium do occur. Only under these circumstances is it possible to have a large collection of fluid without severe symptoms. However when pericarditis bleeds furiously, distention of the pericardium does not take place; and instead, in this case, there is marked restriction of the cardiac action. Changes in the cardiac contour may therefore be pronounced dependent upon the amount of fluid present and rate of accumulation. To recognize such effusions however, requires a high index of suspicion. The purpose of this report is to draw attention to pericardial dysfunction as an essential cause of disorders of the heart, and to show that this may simulate forms of cardiomyopathy. With the decline of tuberculosis generally, the effusions due to infection have decreased in frequency.[1, 2] The pericardial diseases have had a rich history dating back two centuries. Somewhat ironically, the father of physical signs for pericardial effusion and constrictive pericarditis, Kussmaul, who described pulsus paradoxicus and also inspiratory filling of the cervical veins (Kussmaul sign) fell victim to a pericardial disease. It is related by Spodick that Kussmaul saw the head diagnostician in his clinic in Germany for respiratory symptoms. He was thoroughly examined and advised that he could not have pericardial disease. At later studies, when Kussmaul died, he was disclosed to have constrictive pericarditis, and while it was not then an operable condition, the overlooked condition was an embarrassment to the physicians at his clinic.[3]

We have observed a case of chronic pericardial effusion with almost no indications on physical examination. The patient had for a 15-year period a notable increase of cardiac size by x-ray. The findings of this case and its implications are the subject of this report. The radiologic workup in these cases has included signs for fluoroscopic evidence of pericardial fluid (e.g.—nonpulsatile margins and visual separation of a sub-epicardial fat from the margin of the cardiac silhouette). The same pericardial space may be proven by angiocardiography, or by the measurement and investigation of fluid obtained by pericardiocentesis. This case also illustrates the use of these techniques.[3, 4]

Case Report

The patient is a 52-year old white married female whose husband is employed by a world-wide corporation, and who has been in numerous foreign countries. These include Venezuela, Guatemala, Iran, Thailand, Lebanon, Panama, and most recently, Puerto Rico. Prior to each move she received a physical examination in Detroit, and approximately 10 years ago she was noted to have an enlarged cardiac silhouette. In Detroit, this May, a more extensive cardiac workup was performed which reportedly revealed a large pericardial effusion, and a pericardial window was recommended. She chose to have this performed in Omaha as she has relatives in town. A motion mode echocardiogram at Detroit showed pericardial effusion.

On admission she appeared in excellent health and denied all symptoms relating to the cardiorespiratory system. On closer questioning, however, she admitted to slight dyspnea and fatigue on exertion which she attributed to the hot, humid climate where she lived. Slight pretibial edema in the past necessitated the use of diuretics which produced excellent results. She did not have orthopnea, chest pain, heart murmur, rheumatic fever, palpitation, or ascites; there was no history of tuberculosis or thyroid disease.

PMHD: She had the usual childhood diseases and scarlet fever. Hepatitis occurred 5 years ago which resolved without sequelae and a possible episode of dengue fever occurred in Thailand, also 5 years ago.

Operation: T & A as a child.

Drug and Allergies: None.

F.H.: Negative, except for father with hypertension who died of a stroke, and an uncle who died of myocardial infarction.

R.O.S.: Negative.

P.E.: 5′4″, 162 pounds, 98.4, 72 regular, 24, 118/80.

Neck: No neck vein distention. Kussmaul's sign was not present. Carotid pulses 2+ bilaterally. Thyroid was not palpable. Breasts — no masses.

Chest: Lungs were clear to A & P. No posttussic rales. Ewart's sign was not present. Positive Ohio-Blue tip match test.

Heart: RSR: There was no visible precordial or apical impulse. Heart sounds were slightly decreased in intensity. No murmurs or third sounds. No paradoxical pulse was present.

Abdomen: No hepatosplenomegaly or masses noted. Abdomen was obese. No ascites fluid present. Femoral pulses 2+ bilaterally.

Skin: Normal.

Extremities: No pretibial edema.

Laboratory: WBC 6,300 with normal differential; Hb 13.2 gm; Hct. 38%; Indices were WNL. UA unremarkable. BUN 14 mg%; creatinine 0.7 mg%; T-3 28%, T-4 7.6 MCG%. Free thyroxine index 2.14; GTT—normal. ANA —negative. L.E. prep—negative. Rheumatoid test—negative. MS—6 normal. Albumen 3.4 gm%, Alpha—1, 0.1 mg%; Alpha—2, 0.5 mg%, Beta 0.7 mg%, Gamma 1.2 mg% with total of 5.9 gm%.

PPD: Negative. Mumps—Positive.

Pulmonary function studies FEV 72%. Maximum effective flow rate of 110 L/Min. Maximum voluntary ventilation of 41 L/min. (with predicted of 83 L/min.) Initial EKG was interpreted as within normal limits. Echocardiogram showed probable pericardial effusion.

Figure 1: the EKG at the time of pericardiocentesis — Electrical alternans.

Discussion

In this discussion we will cover the differential diagnosis of the 3 major pericardial syndromes:

1. Acute pericarditis
2. Chronic pericardial effusion
3. Chronic constrictive pericarditis

Then we will discuss etiologic diagnoses, (Table 1) emergency therapy, the surgical in-

Table 1
ETIOLOGY OF PRECARDIAL EFFUSION

I. Nonspecific or Idiopathic
II. Infectious
  A. Viral
  B. Bacterial
  C. Fungal
  D. Richettsial
  E. Protozoal
III. Collagen - Vascular Groups
IV. Sensitivity States
V. Inflammations of Contiguous Structures
VI. Neoplastic
VII. Metabolic
VIII. Traumatic
IX. Miscellaneous
  Infectious Mononucleosis
  Sarcoidosis
  Etcetera

dications and related hemodynamic factors, and finally, we will also suggest immune implications related to this case. Pericardectomy was performed by Dr. D. Neis.

Diagnostic aids for pericardial effusion have become numerous and refined. Included are electrocardiographic findings, echocardiography, blood pool scanning, negative and positive angiocardiographic demonstration of fluid and pericardiocentesis. We have already mentioned cardiac fluoroscopy and radiologic methods in the introduction. The use of echo-cardiography deals with either an A mode (as used in this present case) or

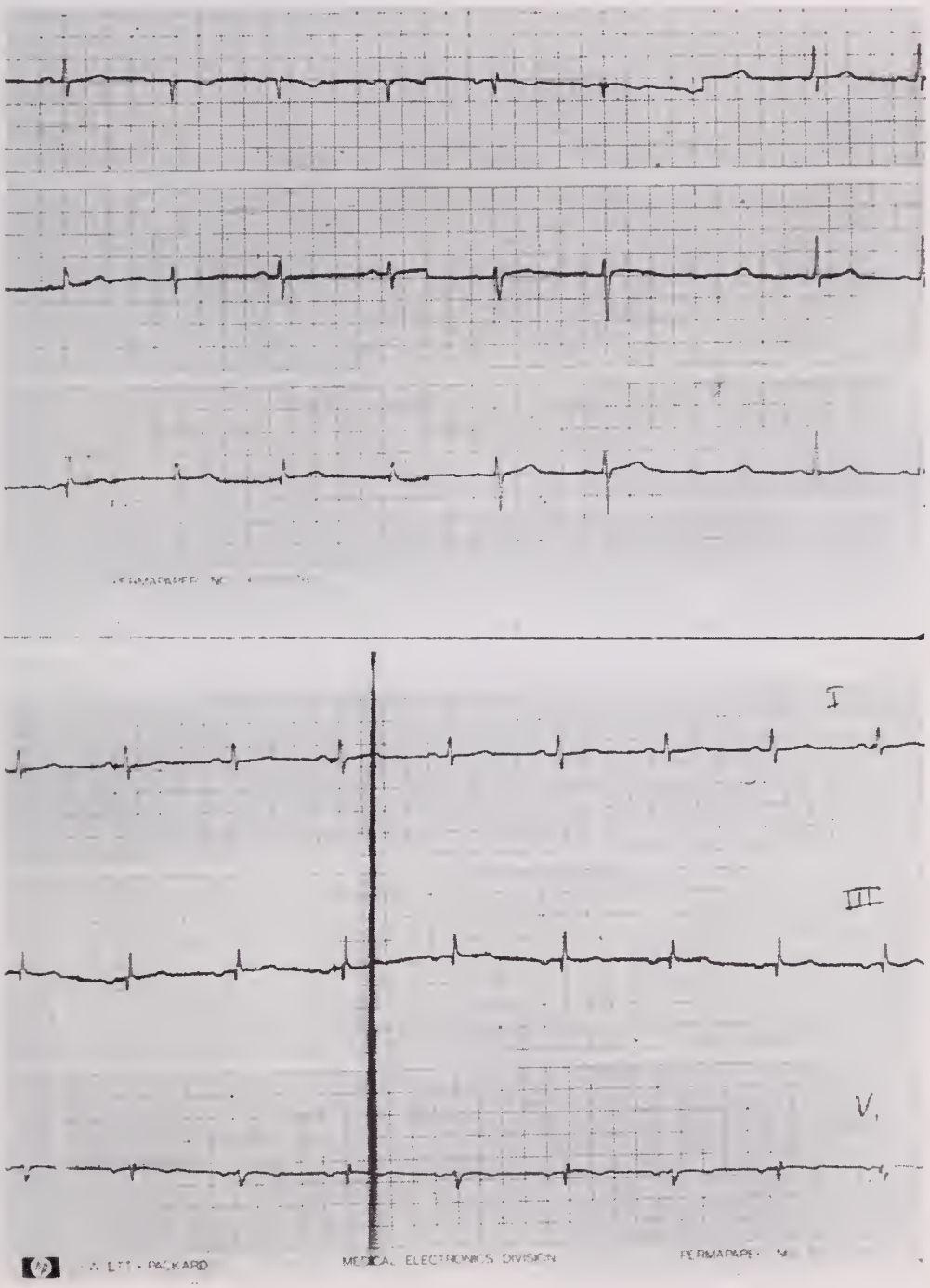

Figure 1 — ELECTRICAL ALTERNANS
In electrocardiogram after pericardial taps. (Especially in Lead V-1 at bottom).

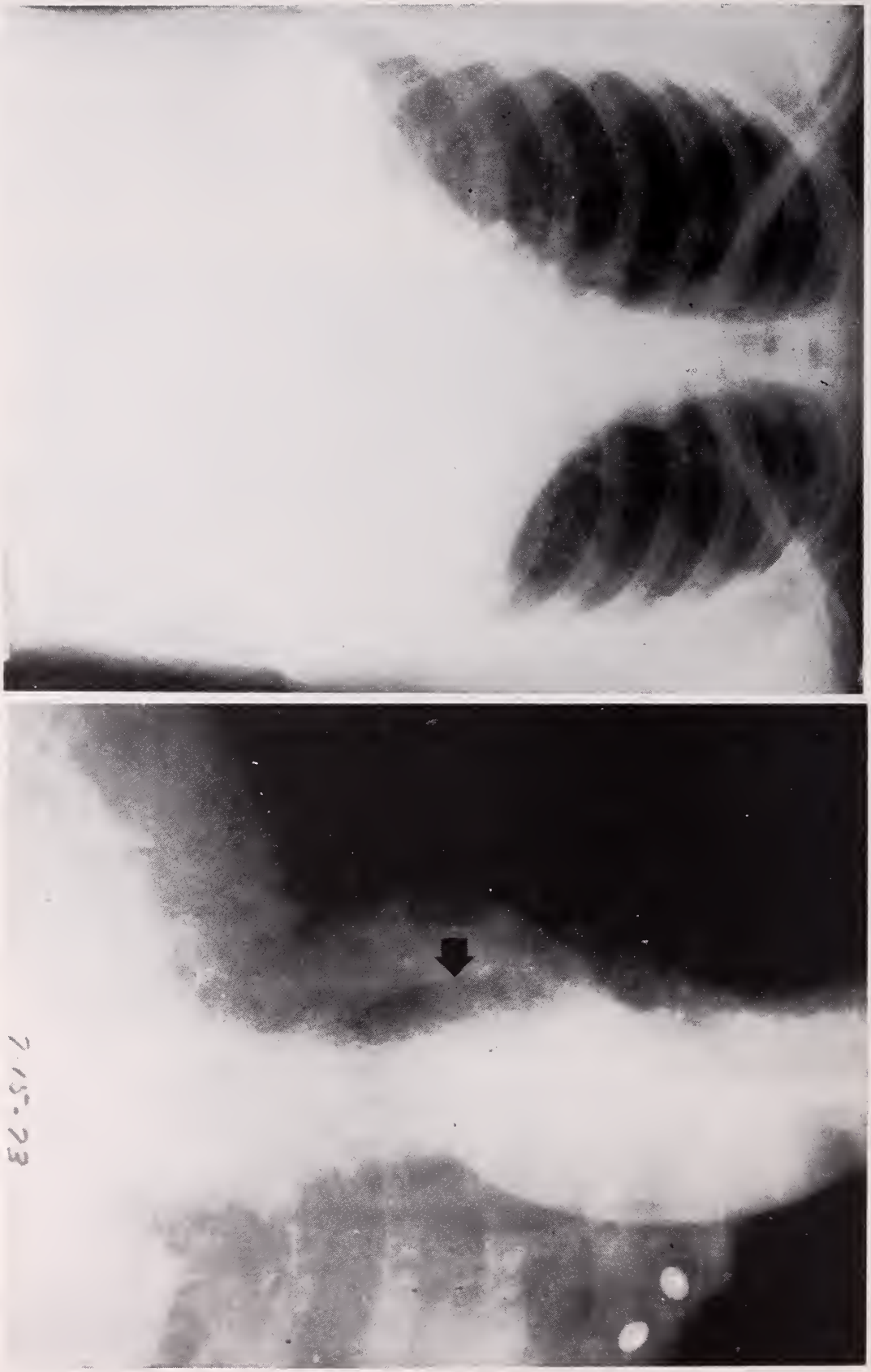

Figure 2. NEGATIVE CONTRAST ANGIOCARDIOGRAM
Chest x-ray and cardiac silhouette before (top) and after (bottom) CO-2 contrasting (right side up decubitus view).

M mode display of the echoes from the anterior and posterior epicardium to demonstrate echo free spaces anterior or posterior to these levels. The echo demonstration of fluid is quite clear once one becomes familiar with the technique and interpretation of these graphs.[5]

The more definitive demonstration of the degree of fluid is brought out by angiocardiography. In this case negative angiocardiography was carried out. (Figure 2). This is done with carbon dioxide injection and is simply the use of rapidly injected carbon dioxide through a needle in a dependent vein usually the left antecubital vein, with the patient lying on his left side. 100 to 150 ml of carbon dioxide are injected and immediately following the completion of the injections at an arm to tongue circulation time interval, several films are exposed in the frontal plane. With the patient in the left side down the decubitus position the gas rises and outlines the internal aspect of the right atrium. This permits one to evaluate the thickness of the atrial-pericardial shadow between the gas in the atrium and the area adjacent. This opaque R. cardiac convex shadow (see arrow) does not normally exceed 5 mm. In the presence of pericardial effusion or thickening, widening of this band is seen. If the band is irregular or deformed, thickening is favored over effusion. The method is simple and has few contraindications. It probably should not be used in patients with intracardial shunts from right to left because of danger of gas embolization to the brain or coronary artery should the gas reach the left side of the circulation. Because of its simplicity and safety we have used this carbon dioxide angiocardiography with good results, but acknowledge that it is slightly less accurate as reported[4] in terms of false negative results than opaque angiocardiography.

The electrocardiogram comes in to play in differential diagnosis at the time of acute changes in pericardial effusion, i.e. when there is tamponade or acute pericardial symptoms the electrocardiogram may show electrical alternans which has its counterpart in mechanical alternation. Electrical alternans was present in the case reported. (Figure 1). The findings were such that the alternation was found only after pericardiocentesis and hemorrhage. The lead V-1 shown in figure 1 shows the presence of a RS and then a QR in alternant leads. When there is total electrical alternation the P and the T also alternate and this is practically pathognomonic for the presence of pericardial tamponade and probably "flip flop" motion or mechanical alternation.[6-10]

The use of pericardiacentesis for diagnosis of pericardial effusion is an old well established technique. The methodology however has had some improvement in technique and there is improved safety with the use of the electrocardiogram attached to the exploring needle through V lead. This will display the epicardial injury potentials when the needle approaches the epicardial surface. Such techniques have been recently elaborated upon.[9-12]

The Etiologic Diagnosis

The etiologic diagnosis of pericardial disease—A table is included indicating the breakdown of the various diagnoses. The most common cause now is non-specific effusion as listed first in Table 1. The features of idiopathic pericarditis are that:

a. Viral illnesses usually precede this or may precede and would be of significance as a clue.

b. The age group is intermediate from the major differential conditions.

Amongst the viral illnesses implicated in this as proven by epidemic occurrence and viral studies are coxsakie A & B, influenza A & B, and chicken pox. It is well accepted that very few diseases affect the pericardium alone. When the other diseases affecting systemic organs such as rheumatic pericarditis and other collagen system diseases or the autoimmune mechanism such as postcardiotomy syndrome are ruled out, then one resorts to placing the patient's diagnosis in the category of idiopathic.[13, 14] Findings serving as clues for idiopathic pericardial effusion are non-specific and in our case presented here the only positive signs of conventional findings were:

1. marked cardiac enlargement by x-ray and;

2. diminished cardiac pulsations by fluoroscopic.

Those features not found, in our case, but usually present in more symptomatic cases are:

1. an increase of cervical venous pressure and hepatojugular reflux;
2. inspiratory filling of neck veins;
3. paradoxical pulse;
4. Ewart's sign. (flatness to percussion left lateral to the spine posteriorly).
5. Systolic rightward movement of the chest impulse.
6. Diastolic precordial thrust often seen in constrictive pericarditis.
7. X-ray evidence of pericardial calcification was not found as it is frequently (50%) in constrictive pericarditis.[7, 8]

However, the pertinent negatives in the patient's findings of this report were:

1. Absence of the palpable apex beat which tended to point toward pericardial disease and effusion as opposed to cardiac dilatation.
2. Distant heart sounds.

When the apex impulse is medial to the left anterior axillary line and medial to the lateral border of cardiac dullness, this may indicate effusion.[2]

The Gluteal Syndrome of Steindler

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IN papers written between 1938 and 1940,[1, 2, 3] Steindler stated that there seemed to be a neuromuscular reflex phenomenon which imitated the pain of radiculitis associated with nerve root compression in the lumbar area. The symptoms were often those of ruptured disk or of a space-occupying lesion. Perhaps because the neuromuscular reflex he spoke of was not and, to my knowledge, has not been explained, Steindler's work has been forgotten.

In any event, he was able to find trigger points along the sacroiliac and gluteal areas in patients who had "sciatic pain." He used procaine to inject these zones, and afforded many of these patients considerable relief of their pain. Steindler was hampered in his work because procaine produced only transient results. He had no cortisone to inject into these areas, which in my experience gives relief of considerably greater duration. He did prove that trigger zones not directly related to the sciatic nerve could produce radiating "sciatica."

In 1964, a young woman who was being considered for possible back surgery because of sciatic pain, was found to have an area of tenderness just lateral to the left sacroiliac joint. Pressure on the area produced considerable pain. She had not noted this area of tenderness prior to the examination. The pressure did not completely reproduce the radiation of pain that she had noted before but there was some discomfort part way down the leg. The patellar reflexes were good bilaterally, as were the ankle jerks. Motor power was symmetrical and of good quality. She complained of slight numbness in the lower leg laterally. Straight leg raising was somewhat limited bilaterally but more on the left. Sitting up from lying flat on the table was difficult and painful. There were no apparent signs of hip joint disturbances.

I was not aware of Steindler's work then, but because the patient was in pain and wanted relief until her back could be operated on I decided to inject the area with a

combination of lidocaine and a depocortisone preparation. She obtained immediate relief of her symptoms. She returned in one week considerably improved; because she had some recurrence of pain the area was again injected. The relief was longer lived. The area was injected four times; surgery was not performed.

Since 1964, we have treated over 100 patients with this mode of therapy. We have had considerable success and the majority of patients have been classified as the "gluteal syndrome of Steindler."

At this point it must be made clear that this treatment is only useful in patients who have the neuromuscular reflex with focal tenderness. True disk disease and other compression syndromes must be ruled out. The findings in the case presentation above are characteristic of those usually found. Other things that are helpful in differentiating between radiculitis and Steindler's syndrome are these. Many of the people with this syndrome noted a cracking sound at the time of their injury but no immediate pain or loss of function. There is usually more stiffness in the mornings and less in the evenings. They usually do not have pain on coughing, sneezing, or straining at stool. There is usually pain if they lie down in bed, face down, and in abduction draw up the leg on the affected side. They usually tolerate having both thighs flexed against their chest better than patients with herniated disks but straight leg raising is usually poorly tolerated. The main diagnostic criterion remains focal tenderness with relief, by injection, of a broader symptom complex than would be ordinarily expected by focal injection.

Some academicians object to injecting a steroid into a focal area of tenderness noting that relief may be due to the systemic effects of the hormones, but the relief afforded by steriods is not immediate unless given intravenously. We have found that ethyl chloride sprayed over the area of tenderness sometimes gives considerable relief of the pain. This therapy is less reliable, and I use it more on needle-shy patients.

The focal areas of tenderness may be quite large, or only 0.5 cm. Only by careful methodical examinations can many of these be brought to light. Firm pressure that is not ordinarily pain-producing is used. The patient is best examined while standing and bending forward over an examining table or in the knee-chest position.

Many patients need repeated injections. Some have symptom-producing disk disease as well as the gluteal syndrome. Some patients gain absolute relief after their first or second injection. Because the gluteal syndrome usually involves acute and chronic muscle strain, repeated injury can reproduce the symptoms, and so in addition to the injections conservative back care is often indicated for several weeks.

Because a significant number of patients have received relief from this therapy more expensive and drastic therapy may not be necessary. Injection of lidocaine with or without steroids is safe and cheap. Careful evaluation of the gluteal and sacroiliac areas is warranted in any patient being examined for back pain. Ruling out this syndrome early in the work up would seem more reasonable than waiting until after more disabling procedures are carried out.

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Radiology Case of the Month

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THIS 57 year old white female noted progressive dysphagia during the six months prior to hospital admission. She denied chest or epigastric pain. There was no history of ingestion of a caustic substance. Roentgenograms during barium study of the esophagus are shown in figure one.

WHAT IS YOUR DIAGNOSIS:

1. Scleroderma
2. Peptic esophagitis
3. Mediastinal mass compressing the esophagus
4. Carcinoma of the esophagus
5. Barrett's (gastric-lined) esophagus

ANSWER — Barrett's (gastric-lined) esophagus.

The distal two or three centimeters of esophageal mucosa normally consists of columnar epithelium and acts as a buffer zone between the acid-pepsin producing gastric mucosa and the squamous mucosa of the rest of the esophagus.[3] Barrett's syndrome, according to Cimmino,[3] results when sheets of columnar epithelium extend abnormally to involve the distal esophagus and occasionally the proximal esophagus as well.

Figure 1

Roentgen examination in Barrett's syndrome shows that the esophagus proximal to the stricture is normal or only slightly dilated. The esophagus immediately distal to the stricture has a tubular appearance and represents the columnar-lined segment. The most distal segment consists of the hiatus hernia.[3, 4] These findings are well shown

Figure 2

in figure two. The upper arrow points to the stricture. Immediately proximal to the stricture is a segment of normal esophagus. The middle arrow designates the tubular, columnar-lined portion of the esophagus and the lower arrow identifies the hiatus hernia. These findings were confirmed by endoscopic examination and serial biopsies.

Some investigators are of the opinion that the abnormally placed gastric epithelium is congenital in origin. Others state that the columnar epithelium is acquired and is a protective response to continuous insult from gastric acid reflux.[1, 5]

The recognition of this condition may not always be apparent from roentgenologic and endoscopic examination. Microscopic sections from biopsies taken at different levels are usually necessary for a definitive diagnosis.[4]

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Between Cases

Diagnosis.

Severe infection in left.

The Examination.

Physical examination reveals a male of short descent.

Advice For The Month. (1)

When in torment and in doubt,
Run in circles, scream, and shout.

Definition.

Hernioplasty: an operation in which the surgeon operates on impulse.

I Didn't Know That.

One out of every six women in the U.S. over 21 is a widow.

I Finally Learned The Difference.

Chyme hasn't gone into the duodenum; chyle has.

Cole

What It Means.

Peritoneum: something that stretches around.

Crystal Ball Department.

Diagnosis: sudden death.

Words I Can Do Without.

Objurgation, secularize.

Advice For The Month. (2)

When in doubt, do nothing.

Acknowledgment.

The pictures of Dr. Stone and Dr. Cole in the July issue of the Journal were taken by Richard E. Garlinghouse, M.D., with his new expensive camera. I hoped to spare him this, but he asked for the credit, and explained the poor quality of the pictures by saying something like look what I had to work with. He meant the doctors.

On Research.

Oh, let us never doubt
What nobody is sure about.

Hilaire Belloc

The Doctor, The Patient, And Russia.

". . . only one question was important: was his case serious or not? But the doctor ignored that inappropriate question."

Tolstoi: The Death of Ivan Ilych

Quote Unquote. (a)

Logic is the art of going wrong with confidence.

Anon.

Section On Mathematics.

Minus times minus equals plus.
The reason for this we need not discuss.

Anon.

The Eye Department.

Vision in left eye 20/20 without glasses; corrected to 20/70 with glasses.
I wouldn't drink out of those glasses.

Bacteria Explode, Too.

In the 1940s, the bacteria population of the U.S. was estimated at 3×10^{25}.

Quote Unquote (b).

Man is only man at the surface. Remove his skin, dissect, and immediately you come to machinery.

Valery.

Section On BP.

105/120.

On Genetics.

Heredity is what you believe in if you have a pretty, bright child.

Anon.

On Orthopedics.

The thumb takes the responsibility, the index finger the initiative.

Anon.

The Report.

There was a grade 1 to 2 diamond shaped systolic murmum.

Section On Geriatrics.

Middle age: Your age plus ten.

Vorspan.

—F.C.

President's Page

WHO SPEAKS FOR MEDICINE?

On more than one occasion during the past few years, I have been confronted with the question "Who speaks for medicine?" The questioner in each instance has spoken with annoyance because of his inabilities to get our profession to come to grips with any semblance of unity on a problem. I can understand the frustrations of these individuals. They have often times been friendly to medicine and have been trying to help, but have been thwarted.

So often, of course, these questions have been of a socio-economic-political nature, and multiple avenues of approach to an answer are possible. Yet, in most instances, the divisiveness has come about because of expressed differences of opinion between individual physicians and the opinion of elected speakers for organized medicine.

As practicing physicians, most of us recognize that multiple approaches to treatments of a disease entity are possible. We make appropriate allowances in our personal and peer review judgements with this in mind. We also recognize that in many instances we must subjugate ourselves as individuals to the team approach in disease treatment. As individuals, our personal area of professional competence is wanting, while collectively we are competent.

Why then, cannot we adopt more successfully this same approach when in the public eye, as in legislative matters? Perhaps we view ourselves falsely as authorities on all types of health questions — when, in fact as individuals we are experts on disease, not health. Collectively, our expertise may be adequate for judgement on health politics, health education, health insurance, etc., but individually we should hold ourselves suspect as "experts."

There comes to mind no single solution to this problem, but of the solutions none seems better than this: Increase your activity in organized medicine: Become conversant with medicine's problems (not just your own): Make your own voice heard in formation of answers to these problems: Select, then elect physicians who are competent to speak for you.

In short, make yourself more effective as a physician by being an active member in your medical societies— County, State, and AMA.

James H. Dunlap, M.D.

Down Memory Lane

1. In this country alone 20,000 deaths a year are due to puerperal sepsis.

2. Tuberculosis usually makes a clean sweep of all of the bony structures with which it comes in contact.

3. In this day and age of focal infection, when everyone is harping about the tonsils, teeth, etc., it is surprising to me how few physicians ever examine the rectum.

4. A focus of infection is a circumscribed area of tissue which has become infected with pathogenic micro-organisms.

5. Out of what is thought to be unsatisfactory functioning in some respects of state medical associations, has developed the medical league idea. A number of states, notably, California, Ohio and Maine, have organized state medical leagues to further the interests of scientific medicine by campaigns of education.

6. We are told, insulin has fallen into disrepute in some localities.

7. The definition of legal insanity as constituting exemption from punishment is that to escape responsibility for a criminal act the individual must have a diseased mind, which at the time of committing the act, rendered him incapable of knowing the nature and consequence of his act and of distinguishing right from wrong.

8. Diagnosis of diseases from focal infections of the throat would include diagnosis of a large per cent of the diseases to which the family is subjected.

9. It is reported that the new West Nebraska Methodist hospital, Scottsbluff, averages from 35 to 45 patients daily.

Nebraska State Medical Journal
September 1924

The Letter Box

Dear Frank:

While reading the current issue of N.M.J., ran across your "The Baby Is a Patient, Too."

Reminded of something I overheard Dr. Hertzler, the country doctor say:

"It's all right to do a circumcision on an infant without anesthesia if he has a long foreskin and a short memory."

Best regards,
G. E. Stafford, M.D.

I Remember

THEY'RE ALL DEAD

I was in charge of the anesthesia service, and therefore of the Postanesthesia Room. The PAR was just outside of surgery, and was really half a room; the other half was the anesthesia workroom. Besides our supplies, we had a desk and a telephone, and space for four patients.

Before we had the PAR, we took our patients from the operating room right back to their own rooms. With the PAR, our trip was shorter and did not involve the use of the elevator, sometimes called vertical transport. Here the patient was turned over to the care of a nurse who was trained for this duty, and we could come to see the patient quickly if we needed to, and without actually leaving the operating area.

I always maintained, being an anesthesiologist, that Recovery Room was not a good name for the PAR, since we had done nothing harmful to the patients from which they must recover. And I also felt that Postoperative Room was better than Postanesthesia Room, since the patient had obviously had an operation as well as an anesthetic.

The doctors' lounge is also just outside the operating theater. It has a telephone, too, for doctors cannot live without a phone, and there is always coffee, and conversation, and even consultation.

I was in the PAR, the room was full of patients just brought in from surgery and sleeping off the effects, and an internist-friend came in and said, "Frank, the phone is dead in the doctors' lounge; is it all right if I use yours?" I said it was, and he tried, and he could not get dial tone.

So he put the phone down, and he said, "They're all dead."

And one of the patients said, "I'm not."

—F.C.

Our Medical Schools

Creighton center

Groundbreaking ceremonies July 17 officially inaugurated the $65 million Creighton Omaha Medical Center in Omaha, Nebraska.

Constructing the new facility is the Creighton Omaha Regional Health Care Corporation. The medical center will replace Creighton Memorial St. Joseph Hospital, which the lay corporation operates.

Construction began August 1 on the hospital and adjoining health professions building. The 403-bed hospital will be built on a horizontal plan, with the top two floors of the five-story building housing patient rooms.

The center is located next to the Creighton University School of Dental Science on the West Campus at 28th and Webster Streets and will occupy 17 acres. The buildings will have a total of approximately 750,000 gross square feet. The hospital will continue to serve as the primary teaching facility for Creighton's Health Sciences Division, which includes medical, dental, pharmacy and nursing colleges.

Plans call for the Boys Town Institute for Communication Disorders in Children to be constructed adjacent to the hospital.

GROUNDBREAKING

The Honorable Caspar W. Weinberger, Secretary of Health, Education and Welfare, was the keynote speaker at groundbreaking. Other dignitaries delivering congratulatory messages were Hon. J. James Exon, Gover-

nor of Nebraska; Hon. William Green, Vice Chairman of the Douglas County Board; and Hon. Edward Zorinsky, Mayor of Omaha. After the invocation by the Most Rev. Daniel E. Sheehan, Archbishop, Archdiocese of Omaha, introductory remarks were made by Frank O. Starr, President of the Board of Trustees of the hospital corporation; A. F. Jacobsen, Chairman of Creighton University's Board of Directors; Rev. Joseph J. Labaj, S.J., President of Creighton; and Thomas L. Flickinger, Executive Director of Creighton Memorial St. Joseph Hospital. Dr. Richard W. Booth, Director of Medical Services and Hospital Planning Director, served as master of ceremonies.

Courses at U of N

Registration is filled for the Family Practice Review at the University of Nebraska Medical Center September 16-27.

In addition to a comprehensive review, newer developments, particularly those not generally used in day-to-day routine of practice, will be presented by specialists from the Medical Center staff.

A course in cardiopulmonary resuscitation will be offered at the Medical Center Monday and Tuesday, October 7 and 8.

Physicians, dentists, physician assistants, nurses, emergency medical technicians and other allied health personnel may attend either day of the course.

The program will discuss cardiopulmonary resuscitation techniques and procedures. It will review and practice the techniques and procedures of cardiopulmonary resuscitation. Each registrant will have an opportunity to practice the proper techniques of resuscitation.

The registration fee, which includes a non-refundable administrative fee of $5, is $30 for physicians and dentists, $20 for nurses and other allied health personnel.

Tuition includes coffee and luncheons.

Because of enrollment limitations, advance registration is required.

Course coordinator is Dr. Denis J. Cuka, associate professor of anesthesiology at the Medical Center.

The course is acceptable for six prescribed hours by the American Academy of Family Practice and qualifies for a .6 Continuing Education Units for nurses.

Metabolism and diabetes

October 24 and 25 have been set as the dates for the symposium on metabolic regulation, insulin metabolism and diabetes at the University of Nebraska Medical Center. Subjects to be presented and their speakers:

"Catecholamine and Prostaglandin Effects Upon Insulin Secretion," by Dr. Paul Robertson, assistant professor of medicine, University of Washington Medical School and clinical investigator, division of endocrinology and metabolism, Veterans Administration Hospital, Seattle;

"The Effect of Pharmacologic Agents on Insulin Secretion," by Dr. Frederick Wolff, professor of internal medicine, George Washington University Medical School, Washington, D.C.;

"In-Vitro Insulin and Glucagon Secretion in Normal and Diabetic Animal Models," by Gerold Grodsky, professor of biochemistry, University of California, San Francisco;

"Pancreatic Islet Cell Toxicity of Cyproheptadine," by Dr. Lawrence J. Fischer, associate professor of pharmacology, University of Iowa, Iowa City;

"The Role of Insulin in Regulation of Hepatic Glucose Metabolism and Gluconeogenesis" by Dr. Philip Felig, associate professor of medicine, and director of Clinical Research Center, Yale University School of Medicine, New Haven, Connecticut;

"Diabetes, Insulin, Fatty Acids and the Control of Protein Turnover in Heart and Skeletal Muscle," by Dr. Leonard S. Jefferson, associate professor of physiology, Pennsylvania State University College of Medicine, Hershey;

"Experimental Models for Investigation of Diabetic Therapeutic Problems," by Dr. William Dulin, manager, diabetes and atheros-

clerosis research, The Upjohn Company, Kalamazoo, Michigan;

"Stress and Diabetes," by Dr. Daniel Frascella, assistant director, Scientific Marketing Operations, Hoechst Pharmaceuticals, Inc., Somerville, New Jersey;

"Dietary Control of Diabetes in Man," by Dr. John K. Davidson, professor of medicine and director of the Diabetes Unit, Emory University School of Medicine, Atlanta, Georgia;

"The Real Problem in the Management of Diabetes," by Dr. Christian Klimt, professor and director, division of clinical investigation, University of Maryland School of Medicine, Baltimore;

"Current Issues in the Evolution of Diabetic Complications," by Dr. David Kipnis, Busch Professor and Chairman, department of internal medicine, Washington University School of Medicine, St. Louis;

"Insulin Resistance," by Dr. Joseph Shipp, professor and chairman, department of internal medicine, University of Nebraska Medical Center, Omaha.

The course is acceptable for 12 prescribed hours by the American Academy of Family Practice.

The registration fee of $30 includes a nonrefundable administrative fee of $5. All registrations received by October 18 will be acknowledged.

Symposium chairmen are Drs. Myron Mehlman, professor of biochemistry, and Richard B. Tobin, professor of medicine and of biochemistry, University of Nebraska Medical Center, Omaha.

The course will be held in the Center for Continuing Education.

Creighton appoints

Joseph M. Holthaus, M.D., Dean of The Creighton University School of Medicine, has announced the following promotions and appointments:

APPOINTMENTS

Richard J. Feldhaus, M.D., Assistant Professor of Surgery

Patricia J. Williams, M.S., Instructor in Audiology and Speech Pathology

John S. Baumstark, Ph.D., Professor of Pathology (tertiary)

Wadi A. Bardawil, M.D., Professor of Obstetrics & Gynecology (secondary)

Jerry L. Bullock, M.D., Assistant Clinical Professor of Obstetrics & Gynecology

Louis C. Martin, M.D., Assistant Professor of Psychiatry & Neurology

Victor A. Saldivar, M.D., Instructor in Pathology

Robert S. Grant, M.D., Associate Clinical Professor of Pediatrics

Patrick E. Brookhauser, M.D., Associate Professor & Chairman, Otolaryngology

John D. Woodbury, M.D., Assistant Clinical Professor of Family Practice (secondary)

David A. Jasper, M.D., Assistant Clinical Professor of Family Practice (secondary)

PROMOTIONS

David A. Jasper, M.D., to Assistant Clinical Professor of Medicine

Jeanette M. Pergam, M.D., to Assistant Professor of Pediatrics

Cervical cancer program

The Creighton University School of Medicine and the University of Nebraska Medical Center have been awarded contracts to conduct a Cervical Cancer Screening Program throughout the State of Nebraska.

Money for the program — $498,301 for a 3 year period has been awarded by the National Cancer Institute to the Nebraska State Health Department, which in turn subcontracted with the two schools.

Dr. Robert Luby, Chairman of Creighton University's Ob-Gyn Department and Dr. Joseph C. Scott, Professor of Ob-Gyn at N.U.

Medical Center who developed the proposal, said goals of the program being undertaken by the two universities are consistent with the goals of the American Cancer Society. They said all such programs being conducted in the state will be coordinated with the State Health Department in an effort to avoid duplication. It is hoped that all women 16 years of age and older will receive a Papanicolau smear test.

Primary testing locations will be The Creighton Health Center, The University of Nebraska Medical Clinic, Creighton and Nebraska Family Practice Outreach Clinics in Omaha and clinics in the following Nebraska cities: Scottsbluff, Tecumseh, Fairbury, Loup City, Kearney, Alliance, Wayne, Fremont, Lincoln, Hastings, North Platte and the Cottonwood Health Center in Tekamah.

Patients who show positive results to the Pap smear will receive further follow-up testing and treatment as needed.

Welcome New Members

K. W. Bruner, Jr., M.D.
Box 853
North Platte, Nebraska 69101

John F. Collins, M.D.
Tekamah, Nebraska 68061

Tai Jin Pak, M.D.
Immanuel Medical Center
36th and Meredith
Omaha, Nebraska 68111

Woman's Auxiliary

Report by Mrs. Bosley

Mrs. Warren Bosley was the Presidential Delegate to the National Convention, Chicago, June 25, 1974.

Nebraskans traditionally enjoy supporting a winning team, and helping the AMA-ERF team reach its million dollar goal this year has been the Nebraska Auxiliary's most unified effort.

Each year since 1970, when Nebraska was recognized as one of the four auxiliaries having the highest percent of increase over the past year, Nebraska has continued its effort. In 1971 we were again recognized for a 23% increase. In 1972 and 1973, we continued to support AMA-ERF, achieving the special merit awards in the over $10 per capita category. Contributions from Nebraska since 1968 total over $47,000.

AMA-ERF is the one program extension committee that has a chairman in *every* county auxiliary, and support is unquestioned. One member-at-large in a small community is alone responsible for over $700 for AMA-ERF this year.

The sale of watches and Christmas cards has continued success. Several "Open House" events provided auxilians and their friends the opportunity for individual selection of cards or watches with economical use of the chairman's time. With addition of other gift items, bazaars were held with or separate from regular meetings.

Social events have been successful fund-raising occasions. One auxiliary held a pot-luck dinner in a member's new home, to which the doctors contributed the prime-rib, $15 per couple, then gave an additional $100 as a group to show their appreciation for the occasion. A larger auxiliary arranged a champagne dinner-theater evening at $25 per couple as a philanthropic benefit. AMA-ERF and other health centered causes benefited from this delightful social affair.

No longer do auxiliary members ask "What is AMA-ERF?" Now this question comes from friends and others in the community who recognize the watches, have given money "In Memoriam," or have heard about the special events. To our devoted and dedicated AMA-ERF Cairman, Irene Kelley, we say "Thanks a million!"

Be near me when my light is low,
When the blood creeps, and the
nerves prick
And tingle; and the heart is sick.
And all the wheels of Being slow.

Tennyson

Coming Meetings

CRIPPLED CHILDREN'S CLINICS—
September 21 — McCook, St. Catherine's Hospital
October 19 — Grand Island, Nebraska Veterans Home

AMERICAN CANCER SOCIETY'S NATIONAL CONFERENCE ON GYNECOLOGIC CANCER; September 18-20, 1975, Marriott Hotel, Philadelphia, Pennsylvania.

AMERICAN CANCER SOCIETY — National Cancer Institute — Eighth National Cancer Conference; September 20-22, 1976, Regency Hyatt Hotel, Atlanta, Georgia.

NEBRASKA MEDICAL ASSOCIATION — Fall Session, October 3-5, 1974, Lincoln, Nebraska.

ANTIBIOTICS AND INFECTION — The Fifth Annual Meeting will be held at the University of Iowa Hospitals, Iowa City, on October 24th, 25th and 26th, 1974. Write to: Dr. Ian M. Smith, Department of Medicine, University of Iowa Hospitals and Clinics, Iowa City, Iowa 52242.

OMAHA MID-WEST CLINICAL SOCIETY — 42nd Annual Postgraduate Assembly, November 11, 12, and 13, 1974, Omaha Hilton Hotel. Write to: (Mrs.) Mary E. Pilloud, Executive Secretary, 1040 Medical Arts Building, Omaha, Nebraska 68102.

AMERICAN ASSOCIATION FOR CLINICAL IMMUNOLOGY AND ALLERGY — Annual Meeting; Pier 66, Ft. Lauderdale, Florida, November 21-24, 1974. Write to: John L. Dewey, M.D., P. O. Box 912, DTS, Omaha, Nebraska 68101.

AMERICAN CANCER SOCIETY — National Cancer Institute — National Conference on Advances in Cancer Management; Part I, Treatment and Rehabilitation, November 25-27, 1974, Waldorf-Astoria Hotel, New York City.

AMERICAN MEDICAL ASSOCIATION — 28th Clinical Convention, November 30-December 4, 1974, Portland, Oregon.

NEBRASKA MEDICAL ASSOCIATION — Annual Session, April 27-30, 1975, Lincoln, Nebraska.

AMERICAN CANCER SOCIETY — National Cancer Institute — National Conference on Advances in Cancer Management; Part II, Detection and Diagnosis, May 1-3, 1975, The Denver Hilton, Denver, Colorado.

AMERICAN MEDICAL ASSOCIATION — Annual Convention, June 15-19, 1975, Atlantic City, New Jersey.

WashingtoNotes

Fees and charges

The House's Interstate and Foreign Commerce subcommittee on health has crushed by an 8 to 1 vote a public utility-like plan that would control physician fees and hospital charges, a provision regarded by many as the most threatening health measure on Capitol Hill.

The vote appeared to assure the doom of the public utility concept both in the full House Commerce Committee and the House. There remains the possibility of Senate approval, however.

The subcommittee adopted a requirement that the local planning agencies monitor individual institutional rates within the state and publicly comment on such rates.

National health insurance

Chances of passage this year of any national health insurance (NHI) proposal by either the Senate or the House seem to be dwindling. The indefinite postponement of Senate Finance Committee hearings on NHI, plus the now ended lackluster once-a-week hearings by the House Ways and Means Committee that dragged out through the spring and early summer seems to indicate the Congress feels it has more pressing matters to deal with, or is baffled as to how to proceed with mandating health insurance for all.

The catch comes as to how the program should be financed. Should the program be financed by a Social Security payroll tax, or by mandated employer-employee financing, or by a tax credit system, such as proposed by the American Medical Association in its Medicredit plan?

Each of the proposed methods for financing a NHI program has powerful allies, both in the Congress and in the private sector. And it would seem that this is a major reason for this Congress' delay. Short of an unlikely compromise brought on by a complete about face by one of the major contending forces, it would appear that the 93rd Congress will not legislate a national health insurance program.

Another reason for congressional foot-dragging on NHI is that time is running out for the 93rd Congress and its "must" work is still piled high. For example, still to surface from the powerful House Ways and Means Committee is its promised tax reform measure, the long ago announced number one priority of the Committee.

And overshadowing all congressional priorities is the loom of time-consuming impeachment proceedings on the near horizon.

Foreign graduates

A slashing attack against the nation's reliance upon foreign medical graduates has been launched in Washington by the Association of American Medical Colleges (AAMC).

The present situation "undermines the process of quality medical education in this country and ultimately poses a threat to the quality of care delivered to the people," according to a report by an AAMC task force on FMGs headed by Kenneth Crispell, M.D., vice president for health affairs at the University of Virginia.

Endorsed by the AAMC executive council, the blunt assault on the immigration of FMGs called for application of the same graduate medical education qualifying examinations to all.

The AAMC noted that FMGs are approaching 20 percent of all physicians here and one third of all current internship and residency training posts are filled by them; and "it is generally acknowledged, though not proven, that the medical care rendered by some FMGs is of poorer quality . . ." the report charged.

Congress has passed and sent to the White House legislation bringing nonprofit hospital employees under the Taft-Hartley Labor Act for the first time.

An AHA official said one result of the law would be to spur further the unionization of hospital workers and to generate new pressures for higher pay and fringe benefits. Inclusion under Taft-Hartley guarantees workers certain organizing, mediating and job rights that are not provided by all states.

For-profit-hospital workers have been included under the National Labor Relations Act for several years.

President Nixon is expected to sign the bill.

The AMA has joined with the Association of American Medical Colleges in opposing the Administration's proposal to cut back on federal aid to medical education.

The Senate Health subcommittee was told by the AMA that "it seems particularly inadvisable to reduce support to institutions with national health insurance now being considered in the Congress."

At the same time, the AMA opposed a provision of a bill prepared by subcommittee Chairman Edward Kennedy (D-Mass.) that would require all medical school graduates to serve in shortage areas for two years. "These draft-like provisions would be unique to the health professions, would constitute a dangerous precedent, and would be contrary to fundamental concepts of the American educational system," said the statement.

Instead, the AMA fully backed provisions to increase support to the National Health Service Program for placing Public Health Service physicians and health personnel in shortage areas for two years.

In backing scholarships for students, the AMA urged that no strings of repayment or compulsory service be tied to them. They "should be limited to giving able students who could not otherwise enter medicine, or other health fields, the opportunity to do so."

Strongly opposed by the AMA was a recommendation in the Kennedy bill for relicensure of physicians. Said the AMA: "Licensure per se cannot assure high quality of medical care or effectiveness of the practice of physicians. Relicensure has the same limitations. Under present circumstances the process of relicensure could severely disrupt the care of patients in many instances because physicians would have to prepare for examinations and be away from patient care while taking them."

Books

Books reviewed

Support Systems and Community Mental Health, by Gerald Caplan, M.D.; 267 pages; hard cover; $12.95; published 1974 by Behavioral Publications, New York.

Dr. Caplan is Professor of Psychiatry at Harvard, and is British born and trained. This book is a collection of ten lectures dealing with the role of social workers, physicians, and nonprofessional caregivers; the shifting of preventive focus from individuals to populations and institutions; the new support systems concept; and other areas.

Chapter headings that interested me were How to Detect the Early Stages of Mental Disturbance in Children, and Practical Steps for the Family Physician in the Prevention of Emotional Disorder.

Six of the lectures and articles go back to the nineteen fifties, two to the sixties, and two are in the seventies. There are references and an index.

—F.C.

Review of Medical Microbiology, by Ernest Jawetz, Ph.D., M.D.; Joseph L. Melnick, Ph.D., and Edward A. Adelberg, Ph.D.; 528 pages; soft cover; $8.50; published 1974 by Lange Medical Publications, Los Altos, California.

This is the eleventh edition of this book, which first appeared in 1954, and has since been translated into Spanish, German, French, Italian, Portuguese, Turkish, and Serbo-Croatian. It has 40 chapters, an appendix, and an index. Tables and figures are scattered through the text.

Our course was called bacteriology, and I was able, by reading a student's notes one evening, to pass an examination the next day, all of this some ten years after graduating. I could not do this now, when more than 500 large pages are merely a review.

But this is a fast-growing field, and this book, with a new edition every two years, keeps up with its growth. The print is easy to read, and the writing is good. Everything I could think of to look up in this buggy world was in the index.

—F.C.

The Human Side of Hospital Administration, by Rod Clelland; 240 pages; 8¾ by 11¼ in; hard cover; price not stated; published 1974 by Prentice-Hall, Englewood Cliffs, N.J.

The author is not a physician, but hospital administratory are not always doctors. The book is divided into 16 chapters. It is a long and wide book, but not thick. The margins are an inch and a half wide; and while there is an index, the type (in the index) is too small.

The radiologist and the pathologist are in the index, but the anesthesiologist is not (he is referred to all too briefly in the text), nor is the hospital-based specialist; I could not find consent or surgery or operation in the index, either.

Still, I like the book. It is a human book. It is readable, which is a thing for which older books on hospital administration are not famous. And it is modern; it even talks, if books can talk, of unions and of retaining the good will of the medical staff.

The author is the director of a 3,600 bed mental hospital and has had five previous administrative positions; he has been President of the Association of Mental Health Administrators. He is photogenic, and his picture is on page 7.

—F.C.

Women: A Bibliography on Their Education and Careers; edited by Helen S. Astin, Nancy Suniewick, and Susan Dweck; 243 pp.; hard cover; $10.95; published 1974 by Behavioral Publications, New York.

This book consists of 352 references to books about women, with a fairly long abstract of each. There are three introductory sections, an author index, and a subject index.

A very useful sourcebook, especially since everything is abstracted for the reader, and particularly if you are a woman.

—F.C.

Books received

Mental Health Intervention in the Primary Grades; by Ann M. Marmorale, Pf.D., and Fred Brown, Ph.D.; 63 pages; paperback; $3.95; published 1974 by Behavioral Publications, New York.

The Therapeutic Community; edited by Jean J. Rossi, Ph.D., and William J. Filstead, Ph.D.; 344 pages; hard cover; $16.95; published 1973 by Behavioral Publications, New York.

Picture Gallery

Dr. Frank Cole speaking to the Woman's Auxiliary to the NMA, Omaha, May, 1974. Left to right, Mrs. Bowen (Caroline) Taylor, Dr. Cole, Mrs. Kenneth (Helen) McGinnis.

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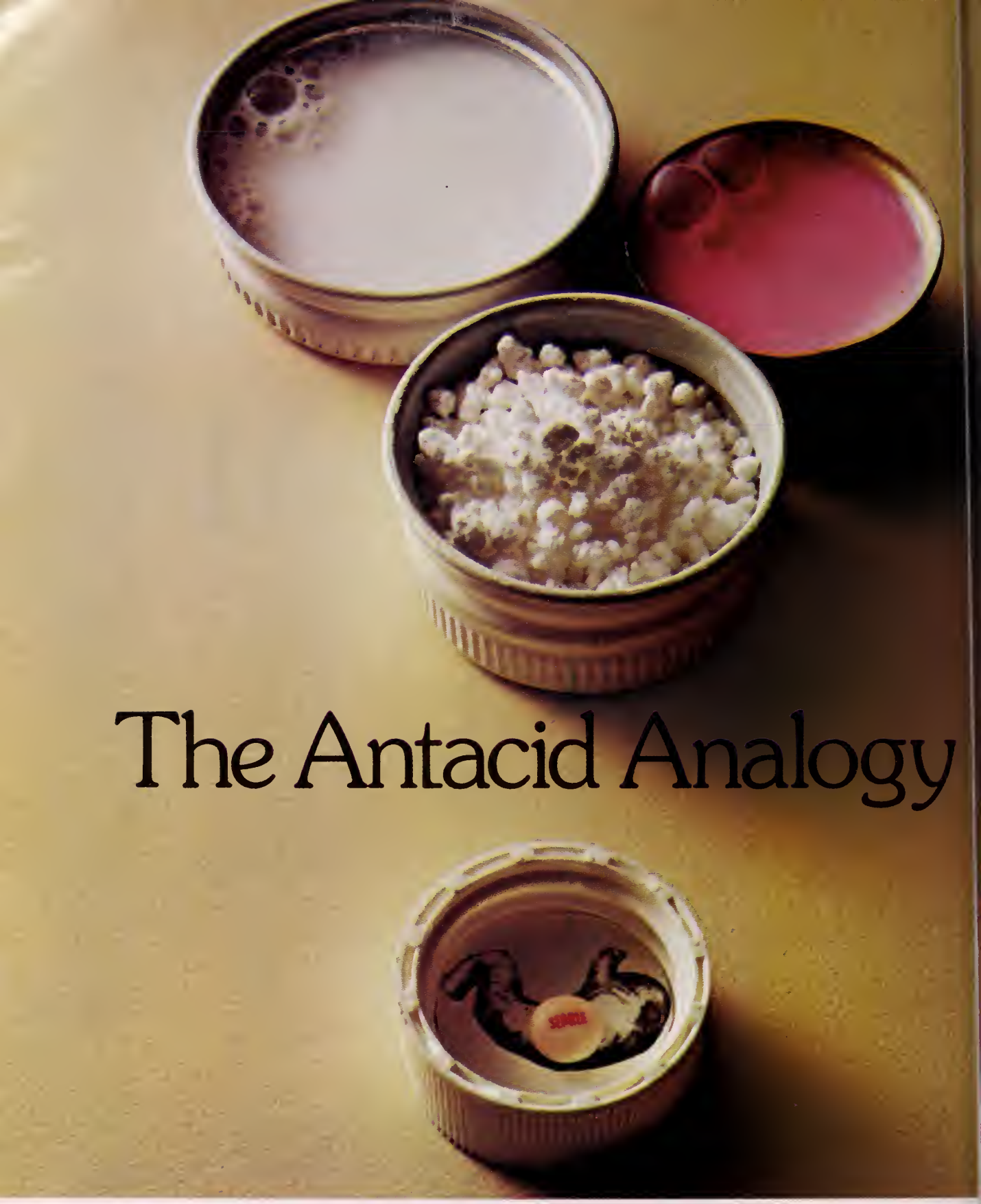

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

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Fever and possibly heat stroke may occur due to anhidrosis.

In theory a curare-like action may occur, with loss of voluntary muscle control. For such patients prompt and continuing artificial respirat should be applied until the drug effect has been exhausted.

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Therapeutic comparisons in peptic ulcer.

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Pro-Banthine® has four.

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ntacids relieve ulcer pain by neutralizing gastric cid. This action is relatively short-lived and they have o other mode of action.

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ro-Banthine suppresses gastric acid ecretion. The antisecretory properties of ro-Banthine are well established. By effectively ocking vagotonic impulses Pro-Banthine suppresses astric secretion to reduce both total and free acid.

ro-Banthine helps relieve pain. ro-Banthine relieves ulcer pain by reducing gastric ecretion and the motility and spasm of the astrointestinal tract.

Pro-Banthine reduces acidity without subsequent acid rebound. The capacity of Pro-Banthine to reduce the secretion of total and free acid in the stomach has been demonstrated in scores of studies. None has demonstrated any significant evidence of acid rebound.

Pro-Banthine activity lasts about six hours. The effect of a single therapeutic dose (15 mg.) of Pro-Banthine lasts about six hours.* Pro-Banthine P.A.®, the prolonged-acting form, is active from 8 to 12 hours. Thus Pro-Banthine may be used to suppress acid, spasm, and pain around the clock, even during the sleeping hours when antacids, to be effective, must be taken almost hourly.

*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

Pro-Banthine complements and enhances the action of antacids.

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cur as well as mydriasis and blurred vision. In addition the following verse reactions have been reported: nervousness, drowsiness, dizziness, omnia, headache, loss of the sense of taste, nausea, vomiting, constipa- n, impotence and allergic dermatitis.

osage and Administration: The recommended daily dosage for adult al therapy is one 15-mg. tablet with meals and two at bedtime. Subse- ent adjustment to the patient's requirements and tolerance must be ade.

o-Banthine P.A.—Each tablet of Pro-Banthine P.A. (propantheline omide) contains 30 mg. of the drug in the form of sustained-release or timed-release beads; on ingestion about half of the drug is released within an hour and the remainder continuously as earlier increments are metabolized. Thus the result is even, high-level anticholinergic activity maintained all day and all night in most patients with only two tablets daily. Some patients may require one tablet every eight hours.

The contraindications and precautions applicable to Pro-Banthine 15 mg. should be observed.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

The Role of the Detail Man

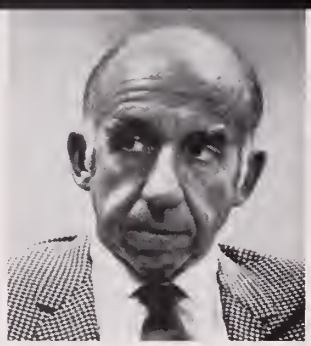
Opinion & Dialogue

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date inforrnation about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihoo on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

Doctor John D. Coe presenting fifty-year certificates of recognition to fifty-year practitioners attending the Annual Distinguished Luncheon.

Taping Demonstration by Wayne Wagner, A.T., University of Nebraska - Omaha at the NMA Sub-Committee on Athletic Injuries exhibit.

Exhibit of St. Paul Insurance Companies which provide NMA endorsed professional liability and group life insurance programs.

Random shot of an exhibit at the Annual Session.

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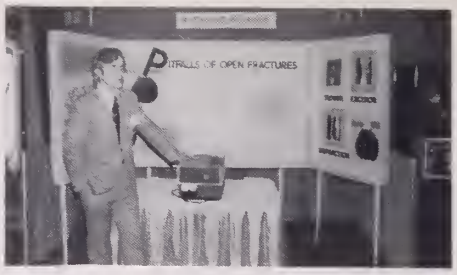

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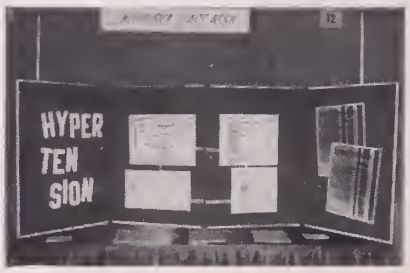

Random shot of an exhibit at the Annual Session.

Medicinews

NHI

The House Ways and Means Committee has completed its hearings on National Health Insurance. The last day of hearings was devoted to Congressional witnesses. Sen. Kennedy (D-Mass.), Chairman of the Senate Health Subcommittee and cosponsor of two major NHI bills strongly endorsed S. 3286. He opposed a free-standing catastrophic approach and called for enactment of national health insurance this year. Also appearing before the Committee was Cong. Roy (D-Kans.) who did not endorse any particular bill but discussed major issues such as accessibility, costs, and quality of health services.

AMA on medical manpower

Just prior to the Independence Day recess, the AMA submitted its views on medical manpower legislation pending before Senator Kennedy's Subcommittee on Health. The primary bill under consideration by the Subcommittee was Kennedy's own proposal, S. 3585, which would, among other things, extend and expand the National Health Service Corps programs, continue construction assistance to medical schools, and continue assistance to students. Of special concern to the AMA was a requirement that all students entering medical school would have to sign an agreement to practice for two years in a medical shortage area upon graduation if so selected to do so by the Secretary. This service requirement would apply regardless of whether that student received federal financial assistance. Kennedy's bill would also create a national council and 10 regional councils which would control the number and geographic location of residency training programs, and in addition carries provisions for the establishment of federal licensure and relicensure requirements. In its statement, the AMA *supported:*

> A continuation of the program of construction loans and grants for medical schools . . . A continuation of capitation grants to medical schools . . . A continuation of assistance through a broad special project grant authority . . . A continuation of loans and scholarships to medical students . . . A continuation of assistance for family practice . . . A continuation of assistance for allied health personnel training . . . A continuation of assistance for public health training . . . A continuation of assistance for students and schools of nursing.

AMA opposed:

> The mandatory service requirements for students, federal control of residency training programs, federal licensure and relicensure requirements.

Proposed rules on program review teams

The Social Security Administration recently published proposed rules governing the implementation of Section 229 of P.L. 92-603 which authorizes the Secretary to exclude from coverage under Medicare and Medicaid items and services rendered by physicians and other providers who he finds have committed program abuses, and to terminate their agreement to participate in these programs. The proposed rules call for the establishment of Program Review Teams for the purpose of reviewing services rendered under Medicare and Medicaid . . . In its comments to Social Security, the AMA noted that certain functions of the teams could be transferred to PSROs under the proposed rules at such time as the PSROs are in operation, but other functions would apparently remain on a permanent basis with the Program Review Teams. AMA also commented that the proposed rules fail to set forth essential elements of the PRT program, noting that the number of members to be appointed to such teams is not specified nor is there any indication as to the relative numbers of physicians, other professional personnel in the health care field, and consumer representatives which

would constitute the respective teams. While major responsibility of the PRTs would be to determine whether charges for items or services rendered were "substantially in excess" of a "person's customary charges," the proposed rules do not define these critical phrases. The Association further remarked that Section 229 and the proposed rules conflict with the PSRO law as well as other sections of the Social Security Act, and could contradict the Medicare reimbursement procedures which are currently set forth in detail in the law. The AMA urged that the proposed rules be withdrawn and that any further action pursuant to Section 229 be republished in the form of proposed rules with adequate opportunity for comment.

Infant diarrhea

Medical scientists from halfway around the world are consulting with University of Nebraska veterinary scientists for help with research on infant diarrhea.

Diarrhea is described as one of the leading causes of infant deaths in the world, especially when related to malnutrition.

The latest scientist to visit the Lincoln campus is Dr. R. R. W. Townley, director of the Department of Gastroenterology at the Royal Children's Hospital in Melbourne, Australia.

The reason for his visit with Dr. Charles A. Mebus, head of the team of Nebraska scientists, is the discovery by the team of viruses that cause calf scours (diarrhea), a costly disease for beef and dairy producers.

The calf scours viruses have also been isolated in a number of other countries.

The Nebraska scientists have developed a vaccine that controls a reo-like virus and have had good laboratory results with a combined vaccine developed to control both the reo-like virus and a coronavirus they have found also to cause calf scours.

As with calf scours, until the Nebraska scientists proved that viruses were involved, scientists studying infant diarrhea were working on the assumption that the disease is caused by bacteria, primarily E. Coli.

When the results of the Nebraska work on calf scours were published, medical scientists started looking for viruses in connection with infant diarrhea.

Included in the search are scientists with the National Institute for Health.

A virus has been found in children with acute diarrhea in England, Canada, Australia, and Singapore. It appears to be a close relative to the reo-like virus first found in Nebraska, according to Mebus.

A team of scientists at the Hospital for Sick Children, University of Toronto, Toronto, Canada, reported:

"Our findings support the view that non-bacterial acute diarrhea in infants is viral."

One of the problems the medical scientists encountered with the virus from children is the difficulty in culturing it, Mebus said.

The viruses in children apparently is as difficult to culture as was the reo-like virus involved in calf scours.

The Nebraska team developed methods to culture the calf reo-like virus and weaken it into a vaccine after much time and many experiments.

One letter from a scientist in Australia opens: "Dear Dr. Mebus: You may well be surprised to find a group of non-veterinarians suddenly taking an interest in your calf scours virus, but I suspect that we will be only the first of many."

His prediction is coming true.

Drug study released

The Office of Technology Assessment has released its report on drug bioequivalency. The panel, chaired by Robert W. Berliner, M.D., Dean of the Yale University School of Medicine, was requested to perform the study to examine the relationships between the chemical and therapeutic equivalence of drug products and to make certain determinations as to whether drug products with the same physical and chemical composition produce comparable therapeutic effects. The conclusions and recommendations of the Office of Technology Assessment, an advisory

group created by Congress, were prepared in response to pending proposals such as the Administration's proposal that Medicare-Medicaid drug reimbursement be based on the lowest cost of generally available drugs. The OTA report also relates to pending drug regulation. Senator Kennedy (D-Mass.), chairman of the OTA's Technology Assessment Board, praised the report and announced plans to offer amendments to S. 3441, the Drug Utilization Improvement Act, which he recently introduced.

Congressional committee modifications

The House Democratic Caucus is scheduled to consider two proposals which would change the structure and jurisdiction of House committees. The proposals, one sponsored by Congressman Bolling (D-Mo.), and the other by a committee chaired by Congresswoman Hansen (D-Wash.), are similar in the way that they would treat committees involved with health legislation. Both would place primary health authority in a new Committee on Commerce and Health. Under the Bolling proposal, the Ways and Means Committee would retain jurisdiction only with respect to the financing mechanism of health programs such as Medicare and national health insurance. The Commerce and Health Committee would have jurisdiction over virtually all other aspects of health legislation. Under the Hansen proposal, the Ways and Means Committee would retain jurisdiction over all aspects of health legislation which is financed by payroll taxes. Commerce and Health would have jurisdiction over all aspects of health legislation financed from general revenues. This would seem to allow the possibility of both committees separately working on national health insurance proposals, depending upon the proposed financing mechanism.

Self-assessment for surgeons

SESAP II, the second in a series of projects designed to help practicing surgeons evaluate their professional knowledge and continue their professional education, is now being completed by the American College of Surgeons.

The College expects more than 20,000 surgeons to participate in the self-evaluation program, for which registration is now opened. Materials will be ready in October. Some 15,000 surgeons participated in SESAP I, which was initiated in 1971.

SESAP stands for Surgical Education and Self-Assessment Program.

It is designed to provide the surgeon with an objective measure of the strengths and weaknesses in his professional knowledge, so that he can take steps to continue his education appropriately. The ultimate goal is to provide patients with more knowledgeable surgeons.

The assessment consists of 750 multiple-choice items, covering all areas of surgery. The surgeon answers the items at his leisure and sends the completed forms to a bonded agency, which in turn forwards them to the National Board of Medical Examiners for a computerized evaluation. Neither the College nor the Board receives the names of the participants, thus assuring complete anonymity and confidentiality.

After submitting his answers, the participant receives a score and a computerized ranking of his standing among his peers. The computer also sends along a personalized critique, congratulating the participant on his performance in the areas where he has done well, and telling him where more work is indicated.

There is no passing or failing grade, nor is there any correlation between SESAP II and clinical competence. SESAP II is designed as a tool to help the surgeon map out a meaningful program of continuing education. If, for example, he finds he is weak in the area of metabolism and shock, he can arrange to attend postgraduate courses and symposia on these subjects at the College's annual Clinical Congress and Spring Meeting, and to focus his reading in this area.

The assessment was compiled by 10 committees comprising 72 of the nation's leading authorities in all areas of surgery, thus con-

stituting what may be the nation's most outstanding surgical "faculty."

An unusual feature of SESAP II is a syllabus containing an in-depth analysis of the correct answers to each of the 750 items. The syllabus, prepared by the same "faculty" that prepared the assessment, will include all the items, illustrations, a critique for each item, references from the scientific literature pertaining to each item, and a comprehensive subject index. Because of the comprehensiveness of the syllabus, and the distinction of the committee that developed it, it will constitute one of the most outstanding surgery texts in the world.

PSRO

HEW Secretary Caspar W. Weinberger has appointed Dr. Cornelius L. Hopper as a member of the National Professional Standards Review Council. The Council advises the Secretary on the administration of the Professional Standards Review Organization (PSRO) legislation.

Dr. Hopper is Vice President for Health Affairs and Director of the John A. Andrew Clinics at Tuskegee Institute, Alabama, as well as Assistant Clinical Professor of Medicine (Neurology) at the University of Alabama College of Medicine.

Dr. Hopper is an Associate of the American Academy of Neurology, a member of the medical societies of Macon County and the State of Alabama and the National Medical Association. He is Chairman of the Task Force on Health Manpower, Alabama Health Study Commission, and a member of the Executive Committee of the Alabama Regional Medical Program. His many contributions to the professional literature include several focused on multiple sclerosis.

The PSRO program was created by Congress as part of the 1972 Amendments to the Social Security Act. The law requires that local, practicing physicians form organizations of their peers to review the care provided in institutions to patients covered by the Federally financed Medicare, Medicaid and Maternal and Child Health programs.

The PSROs are to assure that the care provided to these patients is necessary, that it meets professionally recognized standards of quality and that it is rendered in the most appropriate setting.

Health manpower

The Senate Health Subcommittee is reviewing proposals to extend the Comprehensive Health Manpower Training Act and the Nurse Training Act. Included in the primary bill before the Committee, S. 3585, the Health Professions Educational Assistance Act, sponsored by Senator Kennedy (D-Mass.), are provisions which could require health professions students to agree to serve in shortage areas assigned by the Secretary regardless of whether or not the student received federal financial assistance. Limits would also be set for the total number of residency programs which would be authorized in the United States as well as authority for the Secretary to set limits for the number of residencies within each specialty. The bill further calls for federal licensure and relicensure of physicians and dentists.

Informative

MUST A NEBRASKA PHYSICIAN REPORT?

1. DEATHS?
   The Nebraska Statutes require that whenever the circumstances show it possible that death was caused by neglect, violence, or any unlawful means that the case be referred to the county attorney for investigation.
2. TREATMENT OF AUTOMOBILE ACCIDENT INJURIES?
   No.
3. DROWNING?
   No.
4. GUN SHOT WOUNDS?
   Yes, to the municipal police or to the county sheriff.
5. HUNTING ACCIDENTS?
   No (other than as in #4 above).
6. INDUSTRIAL ACCIDENTS?
   No.
7. INDUSTRIAL DISEASES?
   No.
8. SUICIDE ATTEMPTS?
   No.
9. LIVE BIRTHS?
   Yes, you must file with the local registrar (municipal or county clerk, as appropriate) a certificate for each birth. Additionally, the physician must separately report visible congenital deformities of a newborn attended at birth within thirty (30) days of birth to the Bureau of Vital Statistics, Department of Health of the State of Nebraska. The physician shall also report birth defects and allied diseases on forms prescribed by the State Health Department; such information is kept confidential.
10. COMMUNICABLE DISEASES?
    Yes, all attending physicians shall report to the official local health department or the State Health Department at 1003 "O" Street, Lincoln, Nebraska 68508, promptly, upon the discovery thereof, the existence of any contagious and infectious diseases as specified by the State Health Department.
11. VENEREAL DISEASES?
    Yes, to the official local health department or the State Health Department at 1003 'O" Street, Lincoln, Nebraska 68508.
12. CANCER?
    No.
13. TUBERCULOSIS?
    Yes, to the official local health department or the State Health Department at 1003 'O" Street, Lincoln, Nebraska 68508.
14. CHRONIC ALCOHOLICS?
    No, even if you know or believe it probable that they are driving automobiles.
15. EPILEPTICS?
    No.
16. DRUG ADDICTION?
    No.
17. ABORTIONS?
    Yes, to the State Health Department's Bureau of Vital Statistics at 1003 "O" Street, Lincoln, Nebraska 68508, within fifteen (15) days after each reporting month. Name of patient not required or included in the report.
18. ABUSED CHILDREN?
    Yes, to the municipal police or to the county sheriff.

The foregoing list incorporates questions most frequently asked, and is by no means intended to represent a complete list of all that the statutes or State Health Department rules require by way of reports from physicians.

The law prohibits a licensed physician from willfully disclosing, except as specifically required or authorized by law, any information which he acquired in attending a patient and which is necessary for him to treat that patient.

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SEP 25 1974

NEW YORK ACADEMY OF MEDICINE

Physicians' Classified

Advertisements in this column are at a rate of ten cents per word with a minimum of $4.00 per insertion. Copy must be received by the fifth of the month preceding date of publication and should not exceed 50 words. Advertisements from members of the Nebraska Medical Association will be accepted without charge for one issue. Each advertisement will be taken out following its first appearance unless otherwise instructed. Where numbers follow advertisements, replies should be addressed in care of The Nebraska Medical Journal, 1902 First National Bank Building, Lincoln, Nebraska 68508.

CLINIC AVAILABLE — General practice in furnished clinic. County seat town, SW Nebraska. Three nursing homes in town, good territory. Equipped office available for dentist. Write Box 8, Beaver City, Nebraska 68926.

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WESTERN NEBRASKA TOWN on 180 and U.S. 30 needs two physicians (G.P. or family practice). Fully equipped hospital. Help available in procuring clinic facilities. An ideal community to raise families. Agriculture is principal industry. Contact: Ronald L. Howerter (308) 874-2292 or (308) 874-2610.

IMMEDIATE OPENING — For Ob-Gyn. and Internal Medicine specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg —bottles of 100 and 500; Tel-E-Dose® packages of 100. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg —bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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to help reduce clinically significant anxiety and thereby help improve patient receptivity

Librium® up to 100 mg daily in severe anxiety (chlordiazepoxide HCl)

Please see following page.

Symptom of excessive anxiety:

The patient may have difficulty in accepting medical counsel.

Clinical experience has shown that some unduly anxious patients may tend to deny or minimize their illness and therefore resist seeking or following medical advice. Through its antianxiety action, adjunctive Librium (chlordiazepoxide HCl) can often calm the emotionally tense patient, thereby encouraging physicia patient rapport and, on occasion, making it easier for the patient to accept medical counsel.

for relief of excessive anxiety

Librium® 10-mg capsules
(chlordiazepoxide HCl)

ROCHE

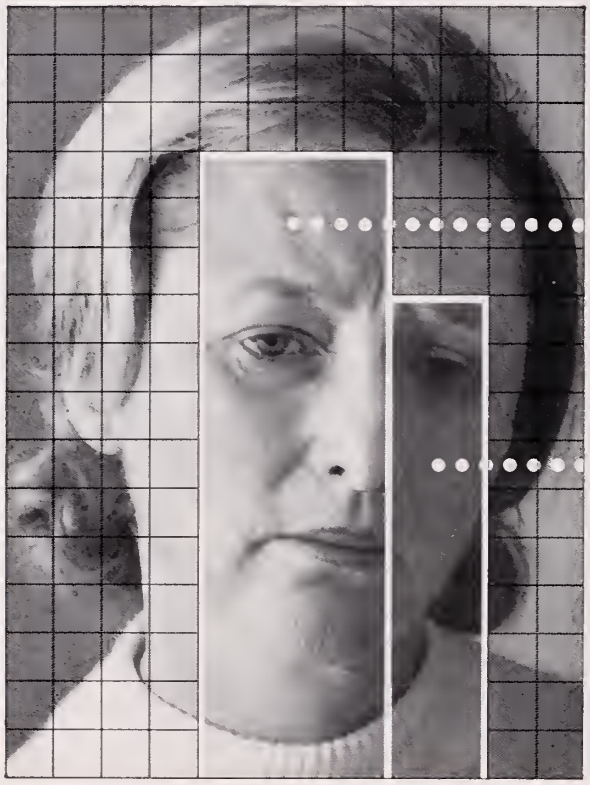
Please see reverse side
for summary of product information.

BALCONY

The Nebraska Medical Journal

October, 1974

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The Nebraska Medical Journal

EDITOR — FRANK COLE, M.D., 1845 "F" St., Apt. 1, Lincoln 68508 OCTOBER 1974 VOL. 59, NO. 10
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Our Medical Schools . . .

Dr. Heaney with NASA.

A Creighton University scientist, Robert F. Heaney, M.D., Vice President for Health Sciences, is assisting the National Aeronautics and Space Administration in evaluating scientific material gathered during Skylab space missions.

Dr. Heaney is one of six panelists who participated in a Skylab Life Sciences Symposium held at the Johnson Space Center in Houston, Texas, August 27-29.

Dr. David Winter, NASA Director for Life Sciences, said the objective of the symposium was to summarize and report to the scientific community the results of the biomedical studies conducted in the Skylab and outer space environments.

Dr. Heaney reviewed material gathered relating to bone loss, and other bone-related problems experienced by America's astronauts. After reviewing the results of experiments conducted during the Skylab flights, Dr. Heaney will present a summary of his interpretation of the experimental findings and will outline suggested areas of future research emanating from the Skylab medical experiment results.

Creighton freshman class.

The Creighton University School of Medicine enrolled 110 students in this fall's freshman class. Dr. Joseph Holthaus, Dean of Medicine at Creighton, said 8,502 applications were received, 327 acceptances were offered and 110 enrolled. This is the maximum number of freshmen medical students Creighton can admit.

The new class is made up of representatives from 55 colleges and universities. There are 92 males and 18 females; the class cumulative grade point average is 3.4.

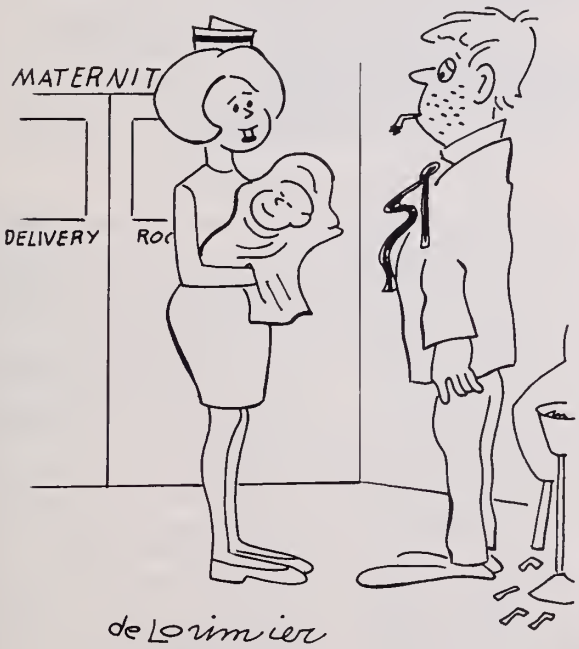
Classes began August 26.

House budget committee organized

The House Democratic Caucus has elected Congressman Al Ullman (D., Ore.), as the Chairman of the new House Budget Committee. Representative Ullman is the second ranking majority member of the House Ways and Means Committee. It is expected that the budget committee will establish overall spending ceilings in each program area for which appropriations are made. The 23 member Committee was established to coordinate the budgeting and appropriation processes.

Congressional schedule

In the aftermath of President Nixon's resignation it is now anticipated that there will be a recess of the Congress beginning August 23 and ending on September 9. Under this proposed schedule the House Ways and Means Committee would have an additional week to continue mark up on National Health Insurance. It was originally expected that the committee would have to delay NHI consideration due to impeachment proceedings which were to begin on August 19.



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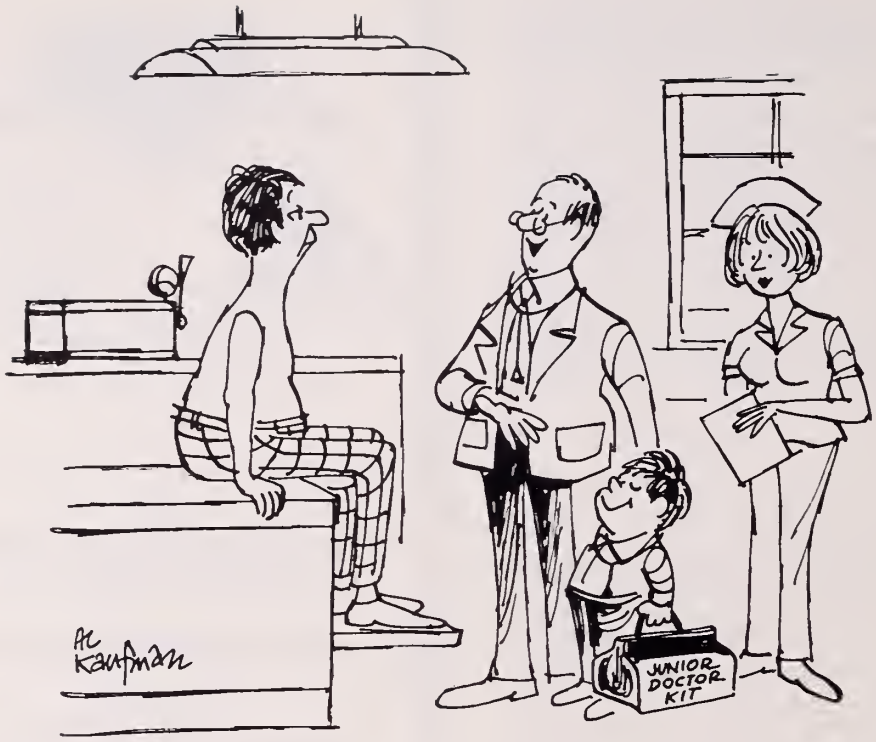

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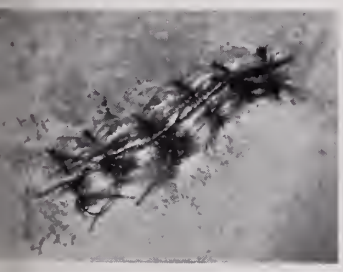

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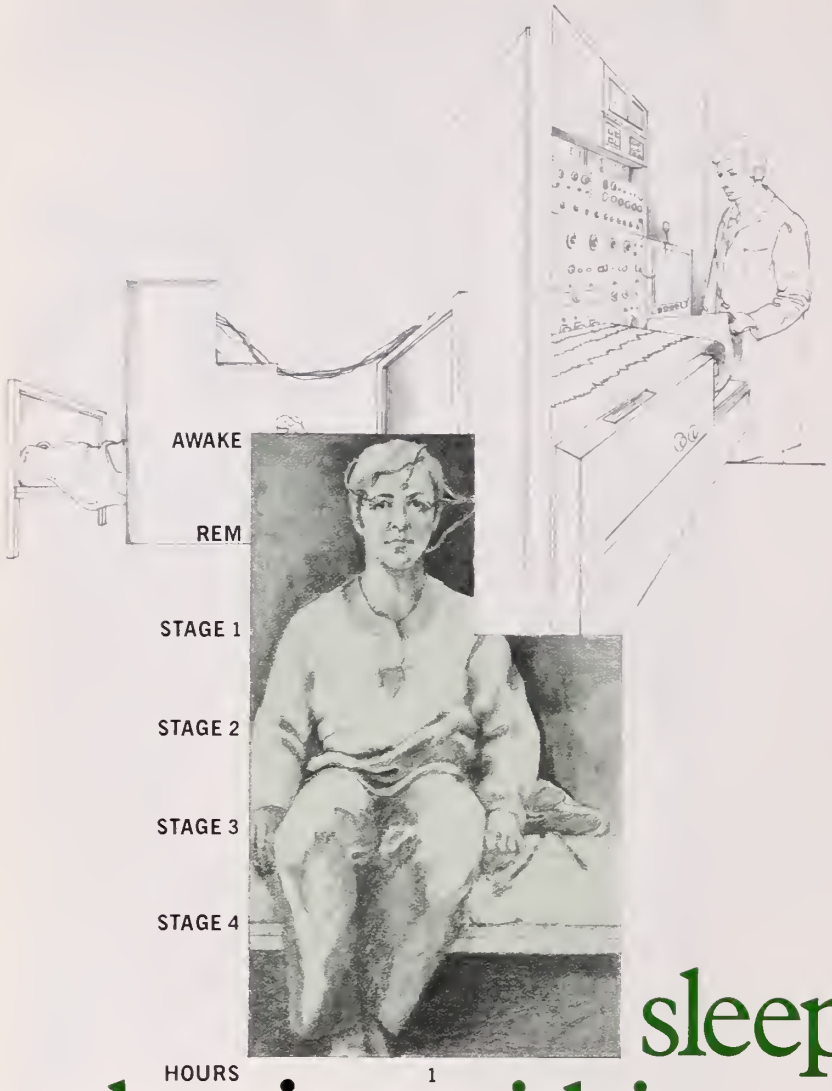

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proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

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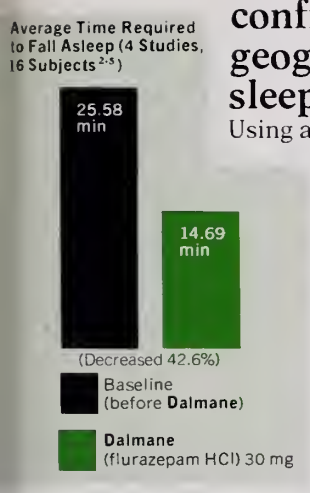


confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

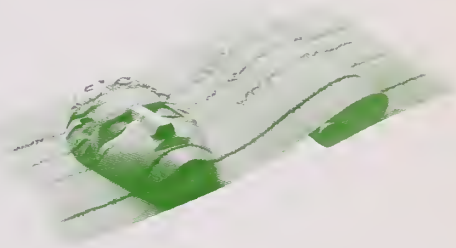
Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.
Contraindications: Known hypersensitivity to flurazepam HCl.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



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One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- sustains sleep 7 to 8 hours, on average, without repeating dosage

REFERENCES: 1. Kales A, *et al: Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association. Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, descreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles and Single Unit Packages of 100 capsules.

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*E.D. Freis: The Modern Management of Hypertension, V.A. Information Bulletin, 11-35.

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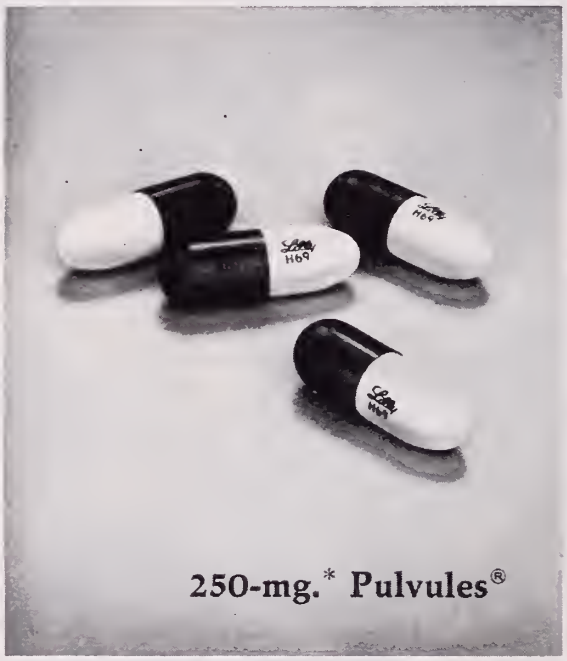

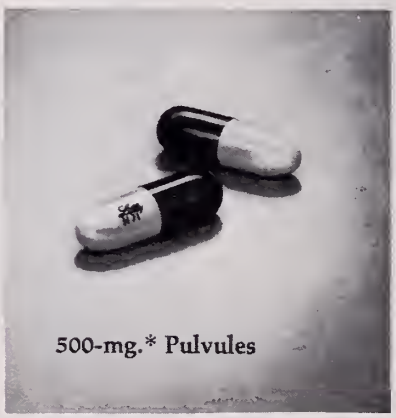

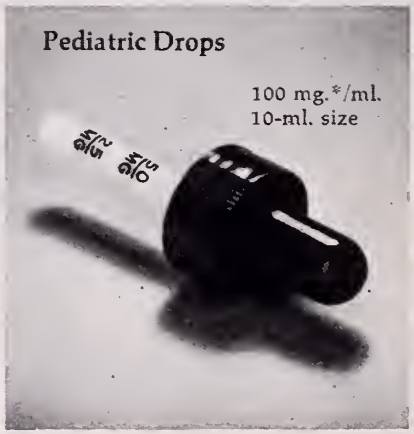

*Equivalent to cephalexin.

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THE NEBRASKA MEDICAL JOURNAL

THE GENTLE ART OF CONVERSATION

I have never been very good at small talk, and it took me a long time to discover the need of it, but I have now blossomed and can carry on with the best. Hello and how are you have some kind of importance; they are a sort of communication; they are chit-chat, or pleasantries, and fill a want, the need to be recognized, and to keep things going.

Much of this prattle consists in remarks about the weather, like it's cold or it's raining, when you know it is. Some of it has to do with what time it is, or with politics, with I-told-you-sos, or with the news. A great deal of it, unfortunately, is made up of poorly conceived witticisms that pass for amenities, in which each tries to outdo the other in a pointless word game.

Carlyle and Ruskin, I think, once spent a whole evening together, during which neither spoke a word. And when one rose to leave, he said he had enjoyed an extremely pleasant visit.

And do we not contribute to this feast of occasionally uninspiring conversation? Well, how are we doing this morning? is our customary greeting. The only difference is this. When a passerby says how are you, he doesn't really want to know. When a doctor says it, he means it.

—F.C.

A REVIEW OF PEERS

A peer is an equal, or an equal before the law, if that is more precise. So when you are judged by a jury of your peers, it becomes a protective device, and one that must be jealously guarded. For you will be tried by people like yourself, and not by your betters; if you are poor, not by the wealthy; and if you are a peasant, not by a supercilious nobleman. You will be fairly tried, and that is the whole point of it.

But a peer is also a noble, and the House of Peers is also the House of Lords; yet this is *not* what the word implies. But there is the danger that what peer really means will be forgotten.

Should an Einstein be judged by twelve Einsteins? At one time, there were supposed to be only twelve people in the whole world who understood him, but now even I have a faint idea of his concepts. Would you try Captain Kidd by a group of pirates? And what coterie would charge a possibly-wrongdoing president?

But these are far-fetched chances and unraised cries. Judge by peers; hold fast to the right to be tried by those who know you and who understand, or big brother becomes judge and jury both, and woe to him who is being sentenced.

Washington is legislators, and legislators are lawyers, and for lawyers to judge doctors is a mockery. Now that so many in and out of Washington are said to be, and even found to be guilty of wrongdoing, it would be pleasant to have them tried by doctors; and I will serve on the jury. But lawyers are tried by lawyers, who have yet to be hostile judges, for are they not their peers?

Is there a peer review for lawyers?

—F.C.

ON BEING CALLED DOC

I remember reading, long ago, that physicians do not like being called Doc. There were two reasons for this: it is an undignified abbreviation of the proper title; and the choice of the condensed form is deliberate, as Freud would say, and is an intentional form of disrespect.

I have never minded it. Hi Doc seems as good and as friendly as Hello Doctor. And to be called either Doc or Doctor is a form of courtesy, I should think.

But I have heard of another theory. If the selection of the too-familiar Doc is meant to be discourteous, it is only when it is used by wealthy patients. When the term

is employed by the poor, it means nothing, it is a perfect synonym for Doctor; it is even endearing.

—F.C.

SHOULD THE DOCTOR SET AN EXAMPLE?

I have read that doctors should set an example to their patients, and I wonder.

Must the doctor take his own medicine? Must he stop smoking, if he has warned his patients? He should tell his patients, and then doctor and patient may smoke or not, as they please. If there is no law to make the patient stop smoking, there is none for the doctor.

Can an older doctor treat children? If the patient is thin, must the doctor be thin; if the patient is young, must the physician be young, too?

Should a fat physician put you on a diet? It is funny, but it is not wrong. If the doctor likes to eat, and doesn't care about his weight, he may still advise his patient who wants to or who needs to lose weight.

Should the doctor exercise if he tells his patient to do it? Not if he doesn't want to. Ought he to take his own advice concerning alcohol or sex or drugs? When he gets a cold, does he force fluids and stay in bed? You can't do both, anyway.

Should the doctor work a 40 hour week? His patients do. Should he stay away from sick people? His patients do.

Would you go to a dentist who has crooked teeth? Should we disbar a lawyer or fire a judge if he runs a red light?

And would you let a bald barber cut your hair?

I do.

—F.C.

AN OVERDOSE OF NUMBERS

Consultation reports are coming to consist of numbers instead of words. Numbers are all right, there are just too many of them. They make the report long and unreadable, they pretend to prestige, and too often their value is negative.

They are almost invariably figures sent by the laboratory, and they show how hard the lab worked, not the doctor. And it is pointless to dictate all these values to be printed in the consultation, when they will all appear again in the lab reports.

There is another and a more serious indictment of this custom, and it is that these reams of numbers substitute for thinking and for things that can be done in the office and are not done.

Numbers are good, I am all for them, and almost anything, I think, can be expressed numerically. But we are getting too much of a good thing.

—F.C.

ON PRESCRIBING

Man is the only animal that likes to take medicine and the Sig on many an Rx reads t.i.d., and this was originally based on common sense without the science that has engulfed us during the past 90 years. Three times a day seems just about right for most things, and twice a day or four times a day may be as good. Taking medicine too often may be bothersome, and infrequent doses may result in overly wide fluctuations in bodily concentrations.

Our forebears may have known little about blood levels, but this is not important. You take a pain pill when you hurt, and the interval may not be reduced beyond a sensible minimum, as three or four hours. In homeopathy, doses of medicine were divided into a string of minidoses, so that the amount in the blood stream or elsewhere in the body would remain more nearly constant.

If you itch, you will apply the ointment when you need it; and if your heart burns, you will swallow the antacid when the fire in your stomach wants putting out.

But we are asleep for something like eight consecutive hours, and this plays havoc with our drug taking. You may not need medication when you are dozing, especially

if it means waking up to take a sleeping pill.

So I suggest that medicine be prescribed, not three times a day, but accurately at 7 AM, 3 PM, and 11 PM; or on waking, in the early afternoon, and on retiring. Or we could devour microdoses every hour, or take the stuff any old three times during the day, and once at three o'clock in the morning. It would be a small sacrifice and a worthwhile one to change medicine from an art to a science.

—F.C.

EQUAL TIME

Now that liberation is thrust upon us, I should like to say that I seem to remember that more boys are born than girls, and that more boy babies die than girl babies. There are a few other things I want to get down while this subject is being thrashed out.

Women live longer than men, and doctors are usually survived by their wives.

We say he and she; and bride and groom, but the groom gets married first; and Mr. and Mrs. And there were Adam and Eve, and Samson and Delilah, and Fibber and Molly. And I think Mrs. Grant is buried in Grant's Tomb, too.

But don't forget Bonnie and Clyde.

—F.C.

ON SIGNING

Artists sign their paintings; and when you buy a new automobile, you will find both the name of the manufacturer and that of the agency attached, requiring you to advertise for them and to pay for the advertisement. If you walk a great deal, and keep your head down, you will find, among other things, that makers of sidewalks have embedded their names concretely.

There is more of this, much more. But it seems to me that a proud surgeon, after finishing a particularly difficult undertaking, which is an unfortunate choice of words, might well be tempted to add his name or his initials at an extremity of the incision.

If things do not go well, we could recall the last dozen or so cases, as they do with automobiles; to which they sign their names.

—F.C.

Ro 4-4602 and Levodopa in Treatment of Parkinsonism — E. M. Miller (Maimonides Hosp, 4802 Tenth Ave, Brooklyn, NY 11219) and L. Wiener. Neurology 24:482-486 (May) 1974.

Twenty-five parkinsonian patients were treated with levodopa and Ro 4-4602, a peripheral decarboxylase inhibitor. With this treatment, the overall improvement score for extrapyramidal symptoms exceeded the optimal improvement scores achieved with levodopa alone by 25%. Gastrointestinal levodopa side effects were abolished in 92% of patients, and cardiovascular abnormalities in 66%. Dyskinesias were more pronounced. Levodopa dosage could be reduced by an average of 60%. No toxic effects or laboratory abnormalities were noted. A comparison between these results with Ro-4-4602 and those achieved with another decarboxylase inhibitor, MK 486, as reported in the literature, indicates that Ro 4-4602 is more potent.

Neurogenic Bladder in Diabetes Mellitus — J. Nissenkorn et al (Central Emek Hosp, Afula, Israel). Harefuah 86:405-407 (April 15) 1974.

In 50 unselected diabetic patients being treated in a diabetic outpatient clinic, 12% had signs of neurogenic bladder dysfunction. There was no correlation between duration and severity of the diabetes and urological symptoms. Diabetic neurogenic bladder is probably more common than is usually assumed, and failure to recognize it is probably due to lack of awareness. Early recognition and proper treatment should help in preventing irreversible changes.

Psychosomatic Illnesses and Biofeedback, Unlocking Answers

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REPORTS describing people achieving suspended animation or control of their brain waves or heart action appear at first glance to be somewhat akin to reports describing people sticking their feet in uranium soil for arthritis, using snake oil, or buying prayer clothes. In fact, most of the early reports concerning regulation of autonomic functions of the body were those received from India describing mystical acts by fakirs. These Indian mystics were described as being able to slow their heart beat, increase and lower their body temperature, survive with very little oxygen for long periods of time while buried underground, and in general, control body functions not normally under voluntary control. The how and why of these actions have been poorly understood. Through hypnotism and hypnotic techniques, however, a suggested relationship between voluntary control and autonomic response has been established.[1] It can be demonstrated, for instance, that in a deep hypnotic trance, skin flushing can be produced, salivation induced, and heart rate and blood glucose levels altered. The Chinese have gone beyond this and used acupuncture, a quasi-hypnotic technique, to perform painless major surgery.

INTERNAL CONTROL

Over the centuries, western man has focused primarily on the external world and how to control that world. He assumed that his internal world, that is the autonomic regulation of his body, was not under his own control. Eastern man, in contrast, seems to have focused on knowledge of his internal world and achievement of its regulation, while assuming that the external world was largely beyond his control. The exception to western preoccupation with the external world began about the end of the 19th century. At that time, in the early developmental phases of schools of psychology, specifically psychoanalysis, introspection and the gaining of some control over the conflicts of internal processes were seen to be basic in the treatment of psychosomatic illnesses. Asthma, duodenal ulcer, and ulcerative colitis were hypothesized to result from traumatic external events and were the expression of intrapsychic conflicts. With the fading of hypnotism as a popular therapeutic modality in the West, however, attempts at direct control of autonomic functions were relegated to a rather unimportant position in therapeutic treatment of psychosomatic illnesses.

TYPES OF LEARNING

Since Pavlov's famous experiments inducing salivation in dogs, a dichotomy has existed, in that reason and voluntary control of skeletal muscles were thought to take place in the brain and spinal cord, the cerebrospinal system, while the autonomic or vegetative system controlled the visceral motor systems. This vegetative system was seen as an inferior system, since reason and voluntary control were thought not to affect it. The involuntary autonomic nervous system was felt to be simply that — involuntary — incapable of the finely differentiated individual responses the musculoskeletal system could make. It was seen experimentally and practically as a system that reacted only passively to such things as a patient's emotions, and did not respond to any higher type of control.

Along with the dichotomy of two distinct nervous systems, it was suggested that a definite distinction could be made between types of learning. It was thought that the only way the autonomic/vegetative nervous system could learn was through the classical Pavlovian type of stimulus-response conditioning. Trial and error, or instrumental

learning, was thought to be the method exclusive to the musculoskeletal system affected by the higher centers of learning, and it was believed that this learning system simply could not be applied and used with the vegetative system.

A NEW CONCEPT — BIOFEEDBACK

In 1969, however, Neil Miller,[2] an experimental psychiatrist, was able to demonstrate that a rat could learn to raise and lower his blood pressure to avoid receiving a shock. From this classic experiment the term biofeedback was coined. The term is new but the concept has been understood and used by psychologists since Claude Bernard (1813-1878) in describing mechanisms used to obtain a vital balance of the internal milieu of cells. Miller, however, introduced the use of instrumentation into this concept, and defined biofeedback as any technique using instrumentation to give a person immediate and continuing signals on changes in body functions which the body is not usually conscious of, such as fluctuations of blood pressure, brain wave activity, or muscle tension.

The technique of biofeedback is based on three conditions: First, the physiologic function to be brought under control must be continuously monitored with sufficient sensitivity to detect moment-by-moment changes. In other words, one needs instrumentation that allows continuous recalibration, so that the instrument can become more and more sensitive as the person is able to control physiologic functions to a greater degree.

The second condition is that the changes in the physiological measure, that is, whatever physiological function is being measured, need to be reflected or fed back immediately to the person. This can be brought about through visual or auditory monitoring of a light signal or buzzer. The last condition is that the subject must be motivated to learn.[3] In other words, some reward must be available for the appropriate response. In animals, the reward may be quite simple: obtaining food or avoiding pain. A more recent procedure of implanting electrodes in the pleasure centers of the brain can also be used. In humans, however, establishing a reward is sometimes much more difficult.

THE CORRELATION BETWEEN EXTERNAL STRESS AND PSYCHOSOMATIC ILLNESS

With the technique of biofeedback, one can begin to correlate some of the available information concerning the development of psychosomatic illnesses. The subsystem of the central nervous system that delivers messages from the external environment to the viscera is the limbic system. The limbic system is the part of the nervous system, made up of the hypocampus and basal ganglia, that is concerned with regulation of self and seems to be at an interface between the body and the external world. The limbic system's command is executed through the autonomic and endocrine systems that regulate the internal world. The chief aim of this system is preserving the organism.[4]

It has been demonstrated in numerous studies[5] that the limbic system is the repository of instinctual behavior — eating, drinking, defense, flight reaction, aggression, and sexual and internal responses. Motivational effects also reside in this system and can be demonstrated when various parts of the limbic system are disrupted either through chemical or electrical means. In experiments with animals, the elementary personality of the animal appears to remain unchanged, even if all the neocortex is removed, as long as the subcortical and limbic systems are maintained intact.

Psychosomatic medicine is interested in the voluntary control of autonomic functions. This control comes closer to a reality through understanding the limbic system, which is very directly related to the regulation of such functions as digestion, renal activity, sexual cycles, basal metabolism, pressure distribution and composition of the blood. The limbic system does have cortical connection through the temporal lobe and to the brain stem reticular system, two areas concerned with the external world, so

it provides us with a pathway into our internal world and its regulation.

Certainly the most classic experiments of Wolf and Wolff[6] have demonstrated that sustained emotions evoked by the environment, such as anger that is not expressed through the somatomotor system, can produce visceral changes. In their patient, for instance, blanching of the mucosa of the stomach occurred when he remained chronically frustrated. As the stress was removed the mucosal blood flow returned to normal. As far back as 1943, Wolf demonstrated experimentally that there is a clear relationship between autonomic changes and subjective emotional experiences, which is a learned response. Using then a basic understanding of the processes of biofeedback, these processes should be able to be brought under voluntary control and different behavior or different visceral response learned.

Indeed autonomic functions can be brought under voluntary control as has been demonstrated in studies with animals. Miller, in his impressive studies, and an increasing number of other workers have been able to demonstrate how multiple autonomic functions can be brought under voluntary control. In studies with humans, Benson[7] and Shapiro[8] have been able to train subjects to voluntarily alter blood pressure and heart rate using biofeedback, and Sargent and Green[9] have successfully applied this method to the treatment of migraine headache.

The voluntary control of autonomic function is in its infancy. Although most of the results of biofeedback have been within the laboratory, clinical application in the treatment of psychosomatic illness is now a reality.

CONCLUSIONS

For centuries, western man has focused on control of the external world but only in the past century has he devoted in-depth research and experimentation to the control of his internal world. Direct voluntary control of viscera was thought impossible until Neil Miller's experiments in 1969 demonstrated otherwise. These experiments introduced the concept of biofeedback. Using the technique of biofeedback, autonomic functions can be brought under voluntary control and undesirable responses altered. Understanding how autonomic functions can be learned shows promise in unlocking answers to the riddle of the development of psychosomatic illnesses.

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The Use of Intravenous Lidocaine Regional Block in Outpatient Fracture Work

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INTRAVENOUS regional anesthesia was first described by Bier in 1908, but the technique did not gain popularity until the early 1960s, when it became popular as a method of regional anesthesia for use in the operating room during surgery on the hand and forearm. Several investigators have reported favorable results with few side effects with this type of anesthesia.

In 1970, we began to use this method for nearly all upper extremity fractures at the supracondylar level of the humerus and distally, requiring anesthesia, in an effort to assess a greater number of patients and refine the technique. Since then we have used this method on 160 patients and have found it to be a safe, effective, and simple method of handling most upper extremity and some lower extremity fractures.

Method and Material

A standard sphygmomanometer is required, and a butterfly needle, a large syringe, 1% Xylocaine solution, and sterile saline for injection. The sphygmomanometer is applied to the arm in the usual fashion, and the blood pressure taken. The cuff is then used as a tourniquet and an I.V. started with the butterfly needle, usually in the dorsum of the hand. The anesthetic injection seems to be more effective if it is performed distal to, or at the site of injury, but if no other vein is available, using the anticubital vein will usually do quite well.

The cuff is then released, and the arm elevated. If it does not cause too much discomfort, it is advisable to evacuate the extremity of blood by wrapping it with an elastic bandage. If this is not possible, elevation of the extremity for one to two minutes will effect adequate evacuation. The cuff is then inflated rapidly to well above systolic pressure, usually about 200 mm Hg, and kept there throughout the rest of the procedure by an assistant, or by applying a hemostat at the bulb. ¼ ml per pound of body weight of ⅓% Xylocaine is then injected (1.8 mg/kg). Most authors have recommended ½% Xylocaine when this method is used for surgical procedures, but we have found that a lower percentage is quite effective for closed reduction of fractures and leaves a greater margin of safety.

The needle is withdrawn after completing the injection. Anesthesia is usually adequate in two to three minutes, but it may take up to ten minutes before complete anesthesia is present. Tourniquet pain does not cause problems for 20 to 30 minutes after the tourniquet is elevated. This allows adequate time to reduce the fracture, obtain a postreduction x-ray, remanipulate if necessary, and apply a short arm cast. The tourniquet can then be released, the cuff removed, and the cast extended to a long arm cast if necessary.

Results

Of the 160 patients, there were 32 fractures of the hand, 54 fractures of the forearm, 51 Colles fractures, 5 distal radial epiphyseal displacements, 3 Montegia fractures, 3 supracondylar fractures, 2 dislocations of the elbow, and several miscellaneous injuries including 3 lacerations repaired in the emergency room, removal of a foreign body in the foot in two cases, and one ankle fracture. Patients were classified by the authors according to results of anesthesia as follows:

Class A — Complete
Class B — Good, but with slight discomfort
Class C — Adequate, but with moderate discomfort

Class D — Fair

Class E — Poor — requiring supplementary analgesia such as I.V. Demerol or Valium

82.5% of all patients were in Class A, and 94.4% in Classes A and B. 5 patients were in Class C (3.5%) and the remaining 3 (2.1%) in Class E. These two patients were both hand fractures. The first 100 patients were monitored carefully with cardiac auscultation after release of the tourniquet, but there were no adverse effects. One patient received the entire dose of Xylocaine intravenously when a pediatric cuff was used on an adult, giving a false high systolic reading, allowing the Lidocaine to leak into the system. He had no ill effects except that his tongue felt numb. After 45 minutes, a new cuff was applied and block repeated with a good result obtained; there were no complications. A second patient had the cuff slip off at the end of the injection, allowing the entire dosage to be received systemically. There were no ill side effects, and after 15 minutes, the procedure was repeated successfully. Our youngest patient was four years old, and the oldest 79. We did not consider a previous history of cardiac disease a contraindication.

There were no neurological signs of lidocaine toxicity. We made sure that the tourniquet was left up for a minimum of 15 minutes to assure adequate fixation of the lidocaine in soft tissues before release of the tourniquet.

Discussion

In the 200 pound adult, only 160 mg (16 ml of 1%) lidocaine is used, which is well below that recommended by most authors. This may be the reason for our lack of neurological or cardiac complications. In children, little more than would be used in a local injection is used. In the 50 pound child, 40 mg (4 ml of 1%) lidocaine is used.

Little or no premedication was needed.

We observed a possible increase in extremity edema in the following 48 hours. This was a subjective observation and not measured. It should be emphasized that a cast check should be made at 24 to 48 hours in the physician's office.

Cost as compared to general anesthesia is considerably less. The patient need not be admitted to the hospital for anesthetic reasons. There is no delay while the stomach is cleared for a general anesthetic.

Local injection into the fracture site usually requires a greater amount of lidocaine, and converts a closed fracture to an open fracture, adding the risk of infection. This type of block is many times less effective, and in addition has the added disadvantage of distorting local tissues. The regional type of block is less painful to administer than the local injection and it is usually easier to find a vein than the hematoma. Nerve blocks; ulnar, axillary, supraclavicular, etc., carry the inherent risk of nerve trauma, and this technique requires greater skill to administer.

Cost of the procedure should be little more than for local injection.

Few arm complaints were noted with tourniquet release with the exception of some tingling. Pain of trauma did not return immediately.

Summary

160 patients with fractures and dislocations, most of which were in the upper extremity, underwent closed reduction in the emergency room under a modified method of intravenous lidocaine anesthesia. The method was found to be extremely effective, rapid, and safe, with no complications observed.

We recommend the use of this technique in the treatment of fractures requiring closed reduction, and have used it in our practice almost to the exlusion of all other methods.

The Price of Surgery

ABSTRACT

The risks of surgery are composed of several identifiable dangers, all of which can be estimated. The advantage to be derived from an operation is similarly made up of various factors, also quantifiable; in addition to non-life-saving factors, such as freedom from pain, cosmetic benefit, and a feeling of well-being.

A method is offered of evaluating risks, not of patients, but of various operations, so that the physician may know that while the patient may be a grade two risk, the operation may be a grade four risk. The surgeon can thus decide if a certain operation on a particular patient has a positive or a negative value.

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IT is a sobering thought to realize that the price of surgery is sometimes death, but it may be less disturbing when this is also the penalty for avoiding the operating room. For some conditions, as malignancy, perforated bowel, and ectopic pregnancy, the course is hardly open to debate; while for other decidedly elective operations, as excision of herniated intervertebral disk, various kinds of plastic surgery, and hemorrhoidectomy, the risk of undergoing surgery is greater than that of avoiding it. In any case, it is worth while to consider the cost of modern surgery.

What is gained is, of course, more than a matter of life and death. Many conditions are not fatal, and this element enters into all surgery; the well-being or improved health which is obtained must be taken as a positive reward value, for which a small fatality risk is not unjustified. The question is, whether the risk is necessary or not, how small is it?

Six different hazards may be considered. The risk of surgery alone is represented by z, and that of anesthesia by s, so that the operative risk may be said to equal (very nearly) $s + z$. It must be remembered, in these calculations, that people have mortality rates aside from surgical conditions (the letter a has been assigned to this), and that this risk and the danger of the surgical condition are diminished by a small amount, h, merely because the patient has been hospitalized; that is, his surgical condition, operated or not, will be improved to a small extent, while the possibility of his dying from accidents is similarly decreased. If he refuses surgery, he is left with the hazard of his original disease, y. And finally, after the operation, there is the fatality rate of what remains of the illness, which may be small, as in the case of varicose vein ligation; or large, as in any operation for malignancy, this is called m.

Anesthesia deaths occur approximately once in every thousand administrations. If we assume the average duration of anesthesia to be two hours, this means one death in each 2000 hours of continuous anesthesia, so that the life span of a person under anesthesia is about 100 days. Actually, no one could be kept anesthetized that long, but the theoretical value is correct, for in actual practice no patient is ever kept under anesthesia for more than half a day. If we consider 30 years to be the life span of the average unoperated individual (not life expectancy from birth; this is 70 years in the U.S.), it is thus shown that anesthesia is one hundred times as deadly as everyday life.

The value a should be considered in testing large groups, but both a and h appear on both sides of the operated vs unoperated table. The risk of operating, r, is evaluated according to the formula $r = s + z + m + a - h$. The danger of not operating, d, is calculated as follows: $d = y + a - h$. The advantage derived from surgery is therefore $y - (s + z + m)$. One further calculation, $\frac{y - (s + z + m)}{y} \times 100$, indicates

what proportion of the risk has been removed (or added); it is not entirely a fair test as the gain can never exceed 100 percent, while the loss can easily do so. Numbers in this column may not be compared for different operations, since what is 100 percent for one procedure is not the same for another. Finally, when y is extremely small, the last column may show a loss of several hundred percent where the actual increase in risk may be very little.

In the accompanying table, numerical values have been assigned to these variables for different operations. It is actually not enough to say that the risk of an operation is a given number of mathematical units; we must know the danger of not performing the operation, and the benefit (in other than life-saving units) to be derived by the patient from the procedure. The value of the operation will then equal the risk of not operating, minus the risk of operating, plus the non-life-saving benefit the patient obtains. The letters a and h are not shown; all amounts given are percentile and are conjectural.

Numbers shown in column 6 (s + z + m) indicate the risk of surgery, in probable deaths per hundred cases. Column 7 shows, in deaths per hundred operations, the gain or loss for each procedure; negative values indicate an increased number of deaths, while positive figures refer to lives saved by 100 such operations.

It is often regarded as standard surgical practice to operate where the diagnosis, particularly if it be that of acute abdomen, can neither be made nor denied. The reasons for supposing that this is the safer course are threefold: the possibility of the patient's having a condition dangerous to life and amenable to surgery, the assumption that there is no danger of dying from the surgery and anesthesia, and the dread of seeing an unoperated person die. But when the diagnosis is in doubt, and when the patient's physical condition is poor, or when the patient has repeatedly demonstrated an extremely small resistance to anesthesia and exhibits only mild symptoms, the surgeon may well be advised to consider what he has to offer the patient, and perhaps to stay his hand. The mildest surgical procedure, the shortest local anesthesia, both carry with them small but real fatality rates. The old saw about the operation being a success has a grain of truth.

Patients with appendicitis, varicose veins, inguinal hernia, or herniated intervertebral disk usually get well or stay well without surgery; this is not meant to be a plea for nonsurgical treatment, but an understanding of the substitution of one risk for another, particularly where the result may be a small loss, compensation for which cannot be shown in mortality tables. And where the risk of operating is not considerably less than that of not operating, the surgery may not be worth the effort and discomfort involved.

A numerical method is suggested for evaluating surgical risks, not of patients,

GAIN OR LOSS ASSOCIATED WITH VARIOUS OPERATIVE PROCEDURES

	y	s	z	s+z	m	s+z+m	y—(s+z+m)	$\frac{y-(s+z+m)}{y} \times 100$ gain	loss
Appendectomy	20.	0.1	1.	1.1	1.	2.1	17.9	89.5	
Varicose vein ligation	0.1	0.05	0.1	0.15	0.1	0.25	—0.15	---	150
Gastrectomy for ulcer symptoms	25.	0.2	2.	2.2	2.	4.2	20.8	83.2	
carcinoma	100.	0.2	2.	2.2	95.	52.2	48.8	48.8	
bleeding	50.	0.2	2.	2.2	2.	4.2	45.8	91.6	
Bowel obstruction	100.	0.15	2.	2.15	1.	3.15	96.85	96.85	
Hernioplasty	0.1	0.1	0.05	0.15	0.02	0.17	—0.07	----	70
Skin graft for burn	50.	0.1	1.	1.1	0.5	1.6	48.4	96.8	
Laminectomy for disk	0.2	0.15	0.5	0.65	0.1	0.75	—0.55		275

but of operations. For some procedures, particularly where the decision to operate is not entirely free from doubt, the surgeon may well consider what he has to offer the patient and what the sacrifice may be. The operating room is rapidly becoming a safer place for the patient to enter, but it is not yet perfectly safe. The surgeon must realize, in bringing to the operating room a patient whose condition may not be good, and whose indications for surgery may not be clear, that the patient may be thus exposed to a heightened fatality risk.

These things should be thought of on a broad statistical basis. We can only conclude, of course, what we already knew, that emergency surgery lowers the mortality rate. I think we can show, in addition, that these things are quantitative and to what extent they are; that surgery is not without its cost; and that the price of purely elective surgery is a small, diminishing, but determinable chance of dying.

Early Results with Aortocoronary Saphenous Vein Graft Surgery*

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Introduction

SINCE an initial report in this journal, 141 additional patients have undergone direct myocardial revascularization surgery between January 1970 and January 1973.[1]

Of the 145 consecutive patients that have had direct myocardial revascularization surgery at Bryan Memorial Hospital the first 80 were evaluated retrospectively. A protocol was established for prospective data collection on the remainder.

Most of these data are related to the immediate postoperative period. With the multiple articles that have now been published regarding experiences with saphenous vein grafts we felt it of interest to present our experience in a community hospital.[2]

Methods

Angina pectoris was classified by New York Heart Association Functional Classes I-IV. A subgroup of preinfarctional angina was defined by the following criteria: (1) Crescendo angina pectoris from a previously stable state or new onset of angina with rapid progression; (2) No electrocardiographic or serum enzyme evidence of acute myocardial infarction; (3) Demonstration by selective coronary arteriography of 70% or greater narrowing of one or more of the three major coronary arteries. Postoperative myocardial infarction was defined as the development of a new significant Q wave (0.04 seconds in duration) in two or more leads. Operative mortality is defined as death occurring during hospitalization.

Grading of coronary artery anatomy was based on the John Hopkins system of scoring the three major coronary arteries (right, circumflex, and anterior descending), with a maximum score for each artery of five: 0 = no lesion; 1 = 1-49% stenosis; 2 = 50-89% stenosis; 3 = several lesions in the same artery, with at least one lesion greater than 50% stenosis; 4 = 90% or greater stenosis; and 5 = total obstruction. Therefore, maximal 3-vessel coronary artery dis-

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ease would be a score of 15. Left ventriculogram grading was as follows: Class I — normal; Class II — one wall (anterior or inferior in the right anterior oblique projection) involved; Class III — two walls involved with either akinesis, hypokinesis, or dyskinesis present.

Most operations were performed with cardiopulmonary bypass, partial hemodilution prime, and a bubble oxygenator. An occasional right coronary artery vein graft did not require institution of cardiopulmonary bypass. Along with moderate hypothermia, the heart was electrically fibrillated, then vented through the left ventricle or left atrium. Coronary arteriotomy was performed in the appropriate area. A dry field for the distal anastomosis was obtained early in the experience with an encircling suture; later with finger pressure, or aortic cross clamping. After the distal anastomoses were performed, patients were gradually weaned from cardiopulmonary bypass while the proximal anastomosis was accomplished. Direct blood flow measurements of the individual grafts were obtained in the last 55 patients. A radial artery cannula and central venous pressure line were routinely left in place, although the latter was changed to a left atrial catheter later in the series. Ventilatory assist with an endotracheal tube was used for the first 12-24 postoperative hours.

Clinical Data

Using the above methods, 223 vein bypass grafts were constructed. This included 106 grafts to the anterior descending coronary artery system, 82 grafts to the right coronary artery system, and 35 grafts to the circumflex coronary artery system. This averaged 1.54 grafts per patient, and varied from 1 to 4. A Y-graft was seldom used; each vein graft was constructed with an individual proximal aortic anastomosis. A direct internal mammary artery anastomosis to a coronary artery was constructed in seven instances. The indication for internal mammary artery anastomosis was a younger patient with a small distal artery.

The average age was 53 years, with the oldest being 73 and the youngest 36. There were 125 males and 20 females. Fifty percent of the patients had a history of prior myocardial infarction, nine percent had a history or findings of congestive heart failure, and thirty percent had a normal resting electrocardiogram.

Sixty seven percent of these patients had Class III-IV angina prior to surgery. The primary indication for surgery in the group of patients that had Class I or II angina was associated cardiac surgical procedures (8 patients), significant stenosis of the left mainstem coronary artery (4 patients), significant stenosis of the left anterior descending artery and prior to the first septal perforator (32 patients).

Table 1 summarizes the operative mortality. The immediate operative mortality was 9 of 145 patients or 6.2%. With the group of Class I and II ventriculograms, the operative risk was only 2.4%, vs. 27% for Class III ventriculograms. Analyzing the coronary artery classification, Class 0-12 disease had an operative risk of 2.9%, Class 13-15 disease had a mortality rate of 13.6%. Four of 13 patients or 30% died when they had the combination of a Class III ventriculogram and Class 13-15 coronary artery disease.

The overall immediate postoperative myocardial infarction incidence was 25 of 145 patients or 17.2%. Five of these 25 patients died. Thirty-eight patients were considered to have preinfarction angina with an 8% mortality rate. In this group there is an 18% postoperative myocardial infarction rate. Twenty-one patients or 14.5% had associated cardiac surgical procedures; ventricular aneurysmectomy (13 patients), prosthetic aortic valve replaced (3 patients), prosthetic mitral valve replacement (1 pa-

Table 1

OPERATIVE MORTALITY*

Coronary Artery Class	Left Ventriculogram Class I	II	III	Total
0- 8	0/22	0/14	1/2	1/38 (2.6%)
9-10	0/21	0/6	0/2	0/29 (0)
11-12	1/17	0/10	1/5	2/32 (6.2%)
13-15	2/13	0/18	4/13	6/44 (13.6%)
TOTAL	3/73 (4.0%)	0/48 (0)	6/22 (27%)	

*—Two patients who did not have postoperative left ventriculogram are excluded from this table.

tient), mitral annuloplasty (1 patient), repair of atrial septal defect (1 patient), ligation of coronary arterio-venous fistula (1 patient), and internal mammary implant (2 patients). One patient died following an aneurysmectomy and another following repair of an atrial septal defect. Both patients had poor left ventricular function, Class III ventriculogram. The operative mortality for revascularization and associated procedure was two deaths out of 21 patients (9.5%). The total risk to the patient with coronary artery surgery is not complete without consideration of the preoperative evaluation. In over 90% of the cases selective coronary arteriography was performed by transfemoral percutaneous technique. In 796 consecutive patients studied by selective coronary arteriography, the mortality has been 0.5%, with myocardial infarction rate of 0.63%.

Discussion

Operative results are comparable with university centers across the country. In more than 25 surgical series of 40 or more cases, the total operative mortality has ranged from 2.5-18%.[2] The operative mortality figures in patients with good left ventricular function in university centers in Milwaukee,[3] St. Louis,[4] Chicago,[5] and Dallas,[6] was 4.0%, 3.1%, 4.0%, and 3.9% respectively. Information regarding ventricular function and operative mortality is not specifically available in many reports.[7-12] The incidence of immediate postoperative myocardial infarction has been as low as 0.7%[13] to a high of 58%,[14] with the most recent reports ranging from 6-30%.[2, 15-18]

From this experience criteria have been developed for selection of patients for coronary artery surgery. This is based on the clinical status of the patient, coronary artery anatomy and the left ventricular function. A myocardial revascularization procedure is recommended to a patient who continues to be significantly disabled (Class III-IV) from angina pectoris after a medical trial, has significant disease in one or more of the three major coronary arteries and has good left ventricular function. Surgery is also considered for any patient with or without symptoms who has either significant left mainstem coronary artery stenosis or left anterior descending coronary artery stenosis at or proximal to the first septal perforator unless severe depression of the left ventricular function is already present. We still occasionally operate upon a symptomatic patient with Class III left ventriculogram if the patient is severely disabled and fully realizing the risk involved and the uncertainty of outcome.

We study all patients who are considered preinfarctional because: (1) Our surgical mortality and postoperative infarction rates in patients with preinfarction angina are not dissimilar from the group as a whole; (2) Our coronary arteriography complication rate in 38 patients with preinfarction angina has been low, i.e. — one infarction and no deaths; and (3) In the past two years we have demonstrated normal coronary arteries in six patients with preinfarction angina. Other centers have also demonstrated normal coronary arteries in this group of patients.[19, 20] If patients are considered to be preinfarctional, and have serious occlusive disease in the left mainstem or proximal left anterior descending coronary artery, we recommend saphenous vein graft surgery. Usually this entails a waiting period of 1-4 days between the time of coronary arteriography and surgery.

Summary

One hundred forty-five patients had saphenous vein graft surgery between January 1970 and January 1973, at Bryan Memorial Hospital. Patients with good left ventricular function with or without associated procedures had an operative mortality of 2.4%. The surgical mortality of patients who had associated procedures was 9.5%. Results in 38 patients with preinfarctional angina were no different from the group as a whole. Three major factors are considered in selection of patients for coronary artery surgery: the patient's clinical status, coronary anatomy, and left ventricular function. The risk of surgery is best categorized by a combination of angiographic severity of coronary artery disease plus severity of left ventricular dysfunction estimated by the left ventriculogram.

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Chronic Pericardial Effusion and Autoimmune Antibodies – A Case Report

C. A. HAMILTON, M.D., Ph.D.
and
M. CHRISTIANSEN, M.D.

PART II

In tuberculosis pericarditis the condition may be somewhat insidious and the diagnosis difficult. The clues leading to this are that most have no apparent malignant lesion but do have central granulomatous lymph node changes. Usually the pleural effusions are very large. Also prior diagnosis of tuberculosis may be present and weight loss frequent. Usually there is persistent fever and signs of chronic illness and if the first and second strength PPD are negative, tuberculosis is most unlikely, especially when a mumps test is positive. The latter condition prevailed in patient M.C. and caused us to rule out a tuberculous diagnosis in the patient presented. The further diagnosis of tuberculosis is made by aspiration of fluid and culture with smear indentification of the organism. At some institutions during the first week of therapy INH and PAS are administered and then pericardial biopsy is obtained through a thoracotomy with specific evaluation by acid fast smear and cultures of the pericardial material. Then if there is a positive finding, "triple therapy" (including also steroids as a fourth agent for treatment) is administered for tuberculosis.[2]

Among the other infections causing massive pleural effusions are trypanosomiasis (Chagas' disease), and our patient did travel in some Latin American countries in mid-America, including Venezuela. However, such disease as a cause for enlarged pericardium is ruled out by the fact that her findings were present prior to going to Venezuela and other foreign countries. Pasteurella tularensis and a variety of fungus infections may cause massive pleuropericardial effusion. Such are coccidioidomycosis and blastomycosis and torulosis, although the most common would be histoplasmosis and actinomycosis, while less often are toxoplasmosis and sarcosporidiae.[7]

Surgical Implications and Pericardial Tap and Pericardiectomy

When shortness of breath and chest pain become constant and the patient has developed an inspiratory filling of the neck veins there is no difficulty in diagnosing tamponade or deciding on pericardicentesis. Some misgivings arise when one is considering tapping the chronic pericardial effusion. Pericardicentesis is a major procedure. It requires the optimal facilities and preparation of the patient together with the safeguards as mentioned before. Also use of electrocardiographic monitoring and protection against electro-shock from the EKG are desirable conventional techniques. Abnormal pulsations of the jugular veins during pericardial effusion (or tamponade) dictate an urgent need for this technique. However, it is indicated in chronic effusions for diagnosis and some have advised the combined use of pericardial catheterization with right heart catheterization for hemodynamic findings concurrently in both. Characteristic features include the M-shaped configuration of the right atrial pressure pulse, the plateau elevation to over one third of the systolic level on the right ventricular pressure pulse contour, and the finding of unequal levels of end diastolic pressure between right ventricle and left ventricle.[11, 12, 14-19]

Pericardiectomy is indicated for chronic effusions[15, 18-20] and was carried out in this case. The amazing findings of practically normal gross appearance of the pericardium together with approximately 1 liter of pericardial effusion made this case nearly unique. We therefore sought some explanation in special studies and already have excluded in this case report systemic diseases such as

lupus, erythematosis, scleroderma, and rheumatoid disease — by negative tests for LE phenomena, times two, normal RA tests, normal sedimentation rate and generally no features involving skin and other organs to support such a diagnosis. The histopathology of the pericardium in case presented was a nonspecific inflammatory change of low grade.

Autoimmune Heart Findings

Pericardial effusion is sometimes found to have immune features, somewhat like the findings in idiopathic myositis.[16, 20-22] One might speculate that the heart is undergoing a rejection process. This could be likened to some of the process which is observed in transplanted hearts. The subject of effusion and autoimmune mechanism has recently been commented on in connection with pleuropericarditis after sepsis.[23] There are no well established pathogenetic mechanisms for idiopathic pericardial effusion. The delayed onset and slow elaboration of the fluid suggests the delayed hypersensitivity reaction and immunologic event to many different infections. This is possibly involved in autoimmune disease.[20] The predeliction for synovial surfaces may be owing to the mechanical irritation because of the mobility of the contiguous visceral and parietal membranes creating a special vulnerability.[22] Circulating antibodies to heart tissue and its entities has been demonstrated in the case reported and indicate autoimmunity but do not define it as a cause or a consequence.[22] Conceivably this case could have resulted by autoimmune mechanisms generated in youth from a low threshold to an opportunistic virus.[23]

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Radiology Case of the Month

DENNIS F. STRAUSS, M.D.
Radiology Department
University of Nebraska School of Medicine

THIS 47-year-old female was admitted to the hospital following sudden onset of severe substernal pain, dyspnea, and extreme apprehension. Examination revealed obvious dyspnea with tachypnea of 42. Breath sounds were decreased at both bases. An electrocardiogram showed right axis deviation with nonspecific ST changes. Arterial blood gases revealed a PO_2 of 60 mm. of mercury. The chest x-ray (Fig. 1), pulmonary arterial perfusion scan (Fig. 2) and xenon ventilation (Fig. 3) study are shown.

Figure 1

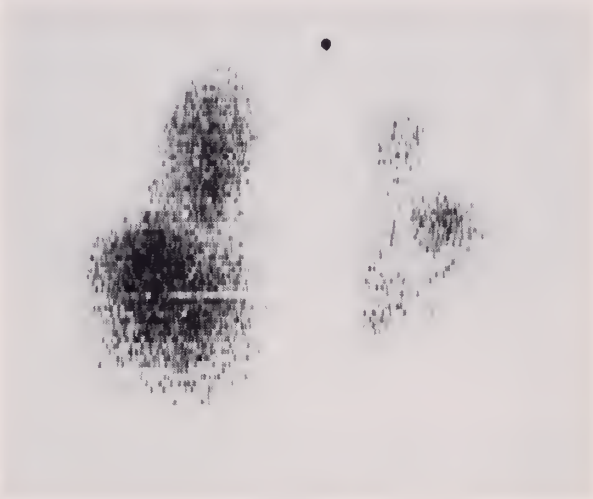

Figure 2

Figure 3

WHAT IS YOUR DIAGNOSIS?

ANSWER — Bilateral pulmonary emboli.

The initial clinical impression of acute pulmonary embolism was not substantiated by the chest x-ray which was considered to be normal (Fig. 1). However, the initial chest x-ray is normal in acute pulmonary embolism in at least half the cases. The pulmonary perfusion scan (accomplished by intravenous injection of radioactively tagged particulate material which will lodge in the pulmonary capillaries) shows numerous areas of decreased activity in a segmental or subsegmental distribution consistent with

multiple pulmonary emboli (Fig. 2). However, any disease such as pneumonia, emphysema and carcinoma, which reduces pulmonary ventilation and or pulmonary perfusion may produce similar changes on the pulmonary perfusion scan.

The xenon ventilation study (accomplished by having the patient inspire radioactive xenon gas) reveals completely normal ventilation of both lungs (Fig. 3). This is the usual finding in acute pulmonary embolism without infarction and serves to differentiate acute pulmonary embolism from the other diseases which may produce abnormal pulmonary perfusion.

Xenon ventilation studies and pulmonary arterial perfusion scans are also useful in the followup of a patient following therapy for pulmonary embolism. The reperfusion of the lung fields should occur quite rapidly, even to the extent of a completely normal appearance in many cases. It should be emphasized that the xenon ventilation study and the pulmonary arterial perfusion study will be predictably abnormal in areas where opacification is seen on the chest radiograph. Consequently, the diagnostic changes in the xenon ventilation and the pulmonary arterial perfusion will be seen in areas which appear normal on the chest x-ray.

Conclusion:

The pulmonary arterial perfusion scan is a very useful and atraumatic technique for evaluation of suspected pulmonary embolus and is quite sensitive in detecting areas of decreased pulmonary arterial perfusion. The addition of the xenon ventilation study enables a more specific diagnosis to be made insofar as it excludes many of the other disease processes which result in abnormal pulmonary perfusion.

Recommended Reading

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My Fifty Years

I received by Bachelor of Arts degree from the University of Kansas in 1921, and Doctor of Medicine degree from the University of Kansas Medical School in 1925.

My practice began in Curtis, Nebraska in 1925, and except for the first few years, I have been the only doctor in this community and a large surrounding territory. It has been a general country practice, with the nearest hospitals fifty miles away, at McCook and North Platte. In the early days, it was a major undertaking to get to either place because of very poor roads. People were not hospital-minded in those days and very seldom went to the hospital except for major surgery or severe sickness. Most patients that would have been hospitalized today, I took care of in their own homes. So, this made a lot of driving for me. And as I remember, I was always plowing muddy roads or snow drifts. I suppose there were good roads at times, but they are hard to remember. Farmers were always willing and ready to help with their horses and later with tractors when I was stuck — which was frequent. I still believe the old Model-T Ford was the best car for that type of road.

In the early days, practically all babies were delivered in the home — some of them in sod houses and under a variety of adverse conditions. Many challenges and difficulties were encountered.

This type of practice has been gratifying but certainly trying at times, especially complicated by blizzards, floods and tornadoes. Curtis experienced one of the early-day polio epidemics which I found especially trying.

I retired in 1972 when we were fortunate in having two young doctors locate here.

Dr. Van H. Magill

President's Page

NATIONAL HEALTH INSURANCE — OUR CHIEF CONCERN

With the passage of Public Law 92-603 in October, 1972, we here in Nebraska, as all across the United States, began the agonizing, scrutinizing process of surveying this law with its multiple ramifications and implications, some very real and others probably imaginary. As the time has passed, most of us have focused on three main objections to governmentally directed Professional Standards Review Organization. In summary our objections and very real concerns have centered upon: 1. The ever increasing encroachment of federalism into our lives; 2. The superimposition of governmentally directed norms and standards of care; 3. The preservation of confidentiality of records.

These three areas of concern have, to me, increased with the passage of time and with greater understanding of their malicious potential. Of the three, I consider the preservation of confidentiality of patients records to be the most important. I will not dwell further on these three items as I am certain all of you have been sufficiently tortured by them, not only within the confines of your own thoughts but by multiple speakers, probably in this very forum. There are, of course, numerous other areas within Public Law 92-603 with which we might concern ourselves with fear. Perhaps greatest among these other areas are the problems inherent in an already overworked medical litigation arena.

As I have listened to and participated in discussions concerning PSRO between physicians in different groups and areas, certain common denominators of confusion and sidetracking of arguments seem to continually arise. For example, I totally agree that the medical profession has done a better job of self-policing than any other profession. I totally agree that other professional groups would do well if they even attempted to play catch-up with us in this regard, and I totally agree that as a physician I would personally prefer to spend more of my time dealing with patients and less of my time dealing with paper work, etc. These comments and many more, in my opinion, tend to side track us from the real concern. That concern, in my opinion, is best summarized by the word "government."

Were it possible to purge the PSRO law of the Secretary of Health, Education, and Welfare and of all things governmental, I believe the remainder of the law embodies principles which our profession could use to good avail. The initials PSRO have come to stand for many things. President Ford, when speaking to the AMA House of Delegates in Chicago, stated that these PSRO initials should mean "Politicians Should Remain Out." I believe additional meanings are proper, appropriate, and meaningful. They might just as well mean "Physicians Should Remain Organized," or "Physicians Should Rule Ourselves."

Now, I would submit to you that if all references to the government could be extirpated from this law, the concept of the law would then not be invalid. The concept does augment programs which we have espoused forever. The programs of self-rule and self-policing, the programs of continuing education, the multiple programs of self-monitoring dealing with all aspects of patient care, and this most certainly must include economic monitoring and self-policing. I be-

lieve that all of us in this room will agree to these "self" concepts.

After having listened to the PSRO discussions literally from coast to coast in our United States and within the framework of these thoughts previously mentioned, I have formed two conclusions from which I cannot escape. 1. In my judgment, the current fact of PSRO is indisputable. This is a fait accompli. 2. No possibility exists for immediate, or in the near future, repeal of this federal law. Within the history of our United States, no federal law, at any time, has ever been repealed without first having been tried. There is no repeal precedent.

If you will accept these conclusions and further realize that PSRO is coming to all of the United States, including the State of Nebraska, then I submit that it is in the best interests of our patients and ourselves that this PSRO effort be directed by Nebraska physicians of our own choosing, not the physicians and organization of the choosing of the Secretary of HEW.

If we can, in Nebraska, at this time, we must accept this as a fact, and we must further accept as a fact that he who controls the finances and he who controls the records in review, will control the doctors and the type of medical care delivered.

I believe it serves the interests of the physicians of Nebraska best if we will instruct our delegates to allow our PSRO Ad-Hoc committee to proceed with their planning. At the present time, this committee has been authorized to continue surveillance and contingency planning dealing with the PSRO problem. I would like to see this Ad-Hoc committee instructed to continue with implementation planning of PSRO, working on the premise that these activities will be implemented in cooperation and coordination with the State Medical Society, and the Foundation for Nebraska Medical Care as proposed at our last House of Delegates meeting, working on a fee-for-service basis, eliminating to as great an extent as possible and practical, governmental financing.

All that has been said to date by me is a prelude to the area of my real concern, and that concern is not PSRO. My contention is that you and I have been dissuaded from focusing on that to which our efforts should have been directed, namely, National Health Insurance.

If our efforts and engeries can be redirected along these lines at this time, I believe you and I, as organized physicians, should attack to the greatest extent possible the current concepts of National Health Insurance. We are already late. Very late. We must hurry to met this issue.

By far the easiest way to lose an argument is to concede your antagonist's basic premise. Organized medicine has done little to this date to dissuade Congress and the American people from the premise that National Health Insurance in one form or another is needed, is proper, and is acceptable. Indeed, as organized medicine, we have even conceded the premise of our antagonists that such is, in fact, proper. We are well along the path to losing the National Health Insurance premise if, for example, we admit the need for governmentally financed catastrophic coverage. I am not denying the need for such coverage, only the need for government financing of this coverage. Is it conceivable to you that any governmentally directed program along these lines would be superior to such offerings as the private insurance industry can make?

If, as we attack the problems of PSRO and NHI, our philosophic persuasions are not accepted by the legislators, then we must continue to strive for modification and amendments to preserve the best possible options and maneuverability for our patients and ourselves.

In conclusion, it is my belief that our efforts will be best served by placing confidence in our PSRO Ad-Hoc Committee and allowing them to proceed with implementation planning for Nebraska on professional review activities, which should include the potential for PSRO and for such other review activities as can be offered to concerned parties on a fee-for-service basis. At the same time, we can remain a part of organized medicine immediately dedicated to the task of mounting a full scale attack on the concept of the need for national health insurance which I perceive to be the death knell of medicine as we know it — the best medicine the world has ever known.

James H. Dunlap, M.D.

Down Memory Lane

1. The commonest complaint of the victim of gallbladder disease is "indigestion."

2. One of the most pernicious habits that has come up in the medical profession is the unnecessary giving of laxatives.

3. Increasing numbers of outbreaks of botulism are being reported.

4. Bleuler has suggested the name schizophrenia, implying a splitting of the personality, which he thinks is the fundamental symptom.

5. The health of its people is a nation's greatest asset.

6. Radium and x-ray treatment of malignant disease was highly praised and roundly condemned by various speakers.

7. During those years the writer saw a number of cases of diphtheria each winter with a high mortality.

8. The existence of multiple standards for the various schools of healing though technically fair, does in reality amount to class legislation.

9. A new addition to St. Mary's hospital, Columbus, was dedicated last month.

10. Whether the accidental amputation of the uvula in doing a tonsillectomy is worth $15,000 is to be determined by the Omaha courts.

11. An epidemic of malpractice suits has broken out in Nebraska.

12. "Childish phantasies" has been overworked lately, in print and pictures.

Nebraska State Medical Journal
October, 1924

The Letter Box

August 19, 1974

Dear Doctor Cole:

Thank you for sending the copies of the August, 1974 edition of the NEBRASKA MEDICAL JOURNAL. This is an excellent issue and I have distributed it to selected members of the AMA Cancer Committee.

Yours truly,

William R. Barclay, M.D.
Assistant Exec. Vice Pres.
American Medical Association

Between Cases

The Cardiology Exam.

Heart sounds were muscled.

Quote Unquote.

Time took away yesterday, and may not bring tomorrow, but today is ours.

Anon.

Department Of Statistics.

If you count all the people in the world, every human being has an average of one testicle.

The History.

The wench slipped.

The Physical.

Lateral motion of the hind foot is narrow. The forefoot motion is normal.

From The Record Room.

Dictated: Tenderness over the occiput.
Typed: Tenderness over the ox-foot.

On Psychology.

Women don't know why they leave oven

doors open when they broil, and they hang phones up backward. They hold the telephone in the right hand and listen with the right ear; men don't.

That's Swell.

He has two to three plus fetal edema.

On Statistics (1).

Respiratory distress syndrome accounts for some 25,000 neonatal deaths in the U.S. each year.

On Pediatrics.

What some children need is a parentectomy.

Anon.

On History (1).

On Dec. 12, 1878, Princess Alice died, as a result of kissing her child, who had diphtheria.

Words We Can Do Without.

Comme il faut, nexus, megrim, nidus, pragmatic, pied-a-terre, piece de resistance.

On Tenderness.

The patient has tenderness over the top of his feet. He has no tenderness there at this time.

Section On Tension.

He had a blood pressure of 46 over 90.

On Statistics (2).

There are about 50,000 cases of child abuse in the U.S. each year. It is reported that at least 700 children are killed each year in the U.S. by their parents or surrogates.

On History (2).

Nebraska has been called the Antelope State, the Black Water State, the Bug-Eating State, the Tree Planters State, and the Cornhusker State.

Crystal Ball Department.

Diagnosis: Swelling of left leg.

A Surgeon's Advice To Surgeons.

When in doubt, hesitate.

It Figures.

The symbol for a Gilbert (look it up) is F.

On Pediatrics.

Bringing up children is easy.

Anon.

On Truth.

If you can't believe fiction, what can you believe?

Anon.

The truth is that there is no truth.

Singer

A Great Deal Of Truth.

The man who wakes up and finds himself famous has not been asleep.

Anon.

—F.C.

Welcome New Member

Wadi A. Bardawil, M.D.
Pathology Department
Creighton Uni. School of Medicine
639 North 27th Street
Omaha, Nebraska 68131

Woman's Auxiliary

PRE-CONVENTION AND ANNUAL MEETING

April 29, 1974

The 48th Annual Meeting was brought to order by Mrs. Warren Bosley, President of the Woman's Auxiliary to the Nebraska Medical Association. The Chaplain, Mrs. Palmer Johnson, gave the invocation. The group then repeated the Auxiliary Pledge. The President declared if there was no objection the Pre-Convention Board Meeting and the Annual Meeting would be combined.

Mrs. Bosley introduced Mrs. Howard Liljestrand, the National President-Elect from Honolulu, Hawaii. Mrs. Liljestrand will be

the installing officer at the Tuesday luncheon. Mrs. George J. Lytton and Mrs. William R. McPhee, the President and President-Elect of the Woman's Auxiliary to the Missouri Medical Association, were introduced as guests.

The minutes of the Midwinter Board Meeting and the 1973 Annual Meeting were approved. The reading committee consisting of Mrs. Y. Scott Moore, Mrs. Guy Matson, and Mrs. Joe Sticher was appointed.

OFFICER'S REPORTS

Treasurer:

Mrs. Gordon Francis reported a balance as of February 27, 1974 of $3,644.51. Total receipts were $3,085.23. Disbursements totaled $3,707.58 leaving a balance on hand of $3,022.16. The total amount in savings accounts is $2,267.98. The books will be audited by July 1, 1974. Mrs. Francis asked that all chairmen present any outstanding bills.

First Vice-President:

Mrs. Hiram Walker reported the State membership totaled 795 people. Of these, 762 are National Members. There are 33 who are State Members only.

Second Vice-President:

Mrs. Y. Scott Moore reported there were 200 letters sent out to the doctors' wives who were not in a county that had an Auxiliary group. Fifty-five memberships were received as a result of this contact. Mrs. Moore recommended that a system be instigated whereby members-at-large would send dues in with their husbands' dues for the State Medical Association.

Historian and Parliamentarian:

Mrs. George Robertson reminded the group we would be celebrating our Fiftieth Anniversary next year. She asked that ideas and suggestions be submitted to the History Committee.

STANDING COMMITTEES

Budget and Finance:

Mrs. Kenneth McGinnis, chairman, presented the proposed budget. A discussion followed concerning the remaining $1,170.00. Mrs. Francis proposed we contribute $400 to AMA-ERF, $300 to NMF and the balance be designated as uncommitted funds. This would allow the President to utilize this for special projects such as workshops or wherever she feels there is a need. The proposed budget was accepted. Mrs. Leland Olson asked that the State Auxiliary consider financial support of the Creighton Medical Student Wives as well as the University of Nebraska WA-SAMA.

By-Laws and Revision:

Mrs. George Robertson read the revision for the by-laws and moved we accept the recommendation to establish life memberships to Auxiliary members to correspond with the Nebraska Medical Association life memberships to physicians. This motion was passed.

Resolutions:

Mrs. Chester Farrell read the report expressing gratitude and appreciation to the officers, chairmen and people responsible in the past year for the work that the Nebraska Medical Auxiliary accomplished. The motion was passed that the complete resolutions be printed in the *Nebraska Medical Journal.*

PROGRAM EXTENSION COMMITTEES

AMA-ERF:

Mrs. J. Whitney Kelley, chairman, announced that as of June 30, 1974, the Federal loans and scholarship program will terminate. $500,000.00 will be deducted from available monies. The total contribution to AMA-ERF is $9,872.22. Mrs. Kelley thanked everyone for helping with this project. At the National Convention, Mrs. Bosley will report on this as one of the major efforts of the Nebraska Auxiliary.

Health Education:

Mrs. Y. Scott Moore, chairman, reported she had attended the Regional Workshop in Cincinnati in October, 1973. The main concerns for Health Education for this year were Aging and Homebound, Ecology, Mental Health, and Nutrition. The resource materials received at the Workshop were presented at the State's Regional Workshops. In December, Mrs. Moore attended

the Nebraska Conference on Special Needs of School Age Parents. She has also been the Auxiliary representative to the Nebraska Inter-Agency Health Council since March. Mrs. Moore is on the Steering Committee for the Conference for Health and Fitness which will take place in the fall. She would like to have the Auxiliary take an active part in this meeting.

International Health Activities:

As there was no state chairman for this committee, Mrs. Bosley reported that she and Mrs. McGinnis had suggested each County Auxiliary collect old eyeglasses as a state-wide project. The President made felt bags for the collection. Hall, Lincoln, Lancaster, Dawson, and Adams Counties took part in this effort.

Legislation:

Mrs. Richard Olney, chairman, reported she had attended the Cincinnati Workshop. She said the LEGS Line worked twice this year. Senator Shirley Marsh discussed Child Abuse Laws at the Workshop in Lincoln. Thirteen wives attended the luncheon for the Senators' Wives in Lincoln. Mrs. Olney recommended we wait a year to entertain this group again. She urged the County Legislation Chairmen to give reports at the county meetings on all Health related bills because medicine will probably undergo many changes through legislation within the next few years.

AD HOC APPOINTMENTS

Health Gallery:

Mrs. J. E. Stitcher reported still no progress on the Health Gallery, but there is hope for getting this project underway.

Inter-Agency Health Council:

Due to the resignation of Mrs. Robert McIntire, Mrs. Y. Scott Moore was asked to replace her as representative from the Auxiliary.

NMF:

Mrs. Stanley Mountford has contacted other health organizations in the Omaha area and has been telling them about the monies available for loans through this fund. She has been promoting this with the hope these other organizations will also support the program. The President asked Mrs. Mountford to write a report for the *Newsletter.*

N-MEDPAC:

Mrs. Leland Olson reported on the special offer during the Annual Convention. A husband and wife can purchase a year's membership to N-MEDPAC for $45.00. Any other time of the year it is $25.00 per single membership. The funds from these memberships are used within the state for supporting candidates endorsed by the NMA for the General Election in November.

Newsletter:

Mrs. Robert Jones expressed her gratitude to Mrs. Bosley for her assistance in editing the *Newsletter.* All counties were asked to participate with articles for the publication. If costs continue to rise, the *Newsletter* format may have to be revised. This will be left for the new Board to decide.

WA-SAMA:

Mrs. Merle Musselman reported a busy and successful year for WA-SAMA at the University of Nebraska. Our support of these enthusiastic student wives is very important. Paula Roudebusch attended the Fall Board Meeting. Members will be attending our activities during Convention.

The President, Mrs. Bosley, gave her yearly report.

County reports of Auxiliary activities were given.

The Chaplain conducted the memorial service. Those remembered were: Mrs. Everett Angle, Lincoln; Mrs. R. Brown, Beatrice; Mrs. W. Brown, Scottsbluff; Mrs. E. E. Farnsworth, Grand Island; Mrs. Robert Murray, Omaha; Mrs. C. C. Tomlinson, Omaha; Mrs. Sam McCleneghan, Valley; and Mrs. W. J. Martin, Omaha.

Mrs. S. F. Moessner, Mrs. Joseph Rogers, and Mrs. James Dunlap were named by the President to serve on the auditing committee.

Mrs. James Carlson presented the slate of officers for the nominating committee.

The slate read as follows:

President — Mrs. Kenneth McGinnis (Lincoln)

President-Elect — Mrs. Y. Scott Moore (Lincoln)

First Vice - President — Mrs. Denham Harman (Omaha)

Second Vice - President — Mrs. Robert Stryker (Omaha)

Treasurer — Mrs. Gordon Francis (Grand Island)

Director—One Year—
Mrs. Robert McIntire (Hastings)
Mrs. Frank Tanner (Lincoln)

Director—Two-Year—
Mrs. Clifford Hadley (Lyons)
Mrs. Jack Ashley (North Platte)

It was moved, seconded, and passed that the nominative ballot become the elective ballot, and these officers were duly elected. Mrs. McGinnis introduced her recording secretary, Mrs. Bowen Taylor, and her corresponding secretary, Mrs. Harold Horn, both from Lincoln.

It was announced the National Convention is to be held in Chicago at the Drake Hotel June 23 through 26. In addition to the Presidential Delegate, Nebraska is entitled to two delegates and two alternates.

Mrs. Bosley and Mrs. McGinnis then presented a slide program which had been shown at the 50th National Auxiliary Convention in San Francisco. This depicted the history of the Woman's Auxiliary to the AMA.

Mrs. Liljestrand thanked the group for the flowers in her room. She reported she had been interviewed on a local television show and had talked about Health Education.

The meeting was adjourned at 4:30.

Mrs. John McCammond,
Secretary.

I Remember

THE UTERUS WAS IN THE PAN

I do not know what a panhysterectomy is, nor does total hysterectomy mean much to me. But I remember one day when I was in charge of anesthesia while a famous surgeon was operating on a woman's insides. I do not know what he began to do, but he explored, as we say, and he decided to take out the uterus.

When it was out, he looked at me, and he said "Spinal, Frank?" I said yes, which meant that the patient was awake, and that was what he wanted to know.

He turned in the direction of the patient's head, and he said, "I'm sorry, Mrs. Harris, but your uterus will have to come out." And she said all right, whatever he thought best.

I have often wondered what he would have said if she had told him no, she wanted to keep her uterus, he wasn't to remove it. He would have insisted, I suppose, but it would have been curious or even just a little funny.

Because that was the day I learned what a panhysterectomy was, or at least one definition.

The uterus was in the pan.

—F.C.

Coming Meetings

CRIPPLED CHILDREN'S CLINICS—
October 19— Grand Island, Nebraska Veterans Home
November 2 — Alliance, Central School Building
November 9 — Norfolk, Elks Lodge
November 30 — Ainsworth, Elm Grade School

ANTIBIOTICS AND INFECTION — The Fifth Annual Meeting will be held at the University of Iowa Hospitals, Iowa City, on October 24th, 25th and 26th, 1974. Write to: Dr. Ian M. Smith, Department of Medicine, University of Iowa Hospitals and Clinics, Iowa City, Iowa 52242.

OMAHA MID-WEST CLINICAL SOCIETY — 42nd Annual Postgraduate Assembly, November 11, 12, and 13, 1974, Omaha Hilton Hotel. Write to: (Mrs.) Mary E. Pilloud, Executive Secretary, 1040 Medical Arts Building, Omaha, Nebraska 68102.

AMERICAN ASSOCIATION FOR CLINICAL IMMUNOLOGY AND ALLERGY — Annual Meeting; Pier 66, Ft. Lauderdale, Florida, November 21-24, 1974. Write to: John L. Dewey, M.D., P. O. Box 912, DTS, Omaha, Nebraska 68101.

AMERICAN CANCER SOCIETY — National Cancer Institute — National Conference on Advances in Cancer Management; Part I, Treatment and Rehabilitation, November 25-27, 1974, Waldorf-Astoria Hotel, New York City.

AMERICAN MEDICAL ASSOCIATION — 28th Clinical Convention, November 30-December 4, 1974, Portland, Oregon.

NEBRASKA MEDICAL ASSOCIATION — Annual Session, April 27-30, 1975, Hilton Hotel, Lincoln, Nebraska.

AMERICAN CANCER SOCIETY — National Cancer Institute — National Conference on Advances in Cancer Management; Part II, Detection and Diagnosis, May 1-3, 1975, The Denver Hilton, Denver, Colorado.

AMERICAN MEDICAL ASSOCIATION — Annual Convention, June 15-19, 1975, Atlantic City, New Jersey.

NEBRASKA MEDICAL ASSOCIATION — Fall Session, October 17-19, 1975, Omaha, Nebraska.

WashingtoNotes

Insurance

Congress's attempt to write a national health insurance law is off again, so far off that most observers believe there is no chance whatsoever for the 93rd Congress to go down in history as the author of mandated health insurance for all.

The method of financing NHI was again the stumbling block, cutting the House Ways and Means Committee down the middle in a 12 to 12 vote (a tie vote defeats an amendment) and thus scuttled a patchwork proposal by Chairman Mills that seemed to many likely to win Committee passage.

The dramatic tie vote came about the morning of August 20 after the Committee had been called to order by Chairman Mills with the admonishment, "We need to work awfully hard."

Staff began to explain the draft compromise point by point in routine fashion to the Committee when Rep. Joel T. Broyhill (R., Va.), said he believed the Committee should be given the opportunity to vote on alternate methods of financing NHI (as opposed to the Social Security payroll tax) such as the tax credit idea in the AMA Medicredit plan. Mills stalled Broyhill off until the financing section of the compromise regarding mandated employer coverage was completed. The Chairman was about to go on, when Broyhill again reminded Mills that he wanted a vote on his amendment. The AMA tax credit approach would be voluntary and consistent with the free enterprise system, Broyhill said.

The first roll call vote of the Committee defeated the Broyhill proposal 11 to 10. One member — Rep. Bill Archer, (R., Texas) — changed his vote from "present" to "aye" and the motion was tied. Rep. Charles Chamberlain, (R., Mich.) walked in and the proposal was ahead 12-11. However, Rep. Herman Schneebeli, (R., Pa.) showed up to cast a "no" vote, and the tie 12-12 tally defeated the Broyhill proposal.

This was the beginning of the end. Rep. Omar Burleson, (D., Texas) lost 12-12 on his bid to substitute the financing proposed by the health insurance industry's NHI plan. The crusher came at the afternoon session when the Committee approved 11 to 7 a motion to make voluntary rather than mandatory the compromise provision for the poor and the self-employed.

The following morning shortly after the Committee had convened, Chairman Mills threw up his hands, saying: "I've never tried harder on anything in my life. But we don't have it. I'm not going to go before the House with a NHI bill approved by any 13-12 vote." He indicated he believed chances of reaching a future agreement on NHI were dim.

The forced abandonment of his compromise plan was a bitter defeat for Mills and for the Administration which had been working closely with the Chairman to steer a measure through the Committee. President Ford had urged Congress to give NHI top priority this year.

The up and down fortunes of NHI have now slumped to the point where only some drastic intervention by President Ford could save the measure for this year.

The self-employed doctor

Self-employed physicians are about to receive some cheery news from Washington.

The House and Senate have passed and sent to the White House a liberalization of the Keogh law providing tax deferrals on retirement savings of self-employed people.

This means that physicians in this category can immediately start setting aside more money subject to tax deductions in qualified retirement programs. The bill's Keogh plan arrangement is retroactive to July 1, 1974.

There is no threat of a Presidential veto to cast any shadow on the legislation becoming law.

The bill substantially boosts the savings subject to tax deductions. The present

Keogh plan allows the self-employed to set aside tax free up to 10 percent of their annual income with a $2,500 a year maximum. The new law will allow 15 percent of earned income not to exceed $7,500 a year

Retired military MDs

Retired military physicians may now accept positions as active physicians with the Defense Department without any loss of their retired pay. Defense hopes the exception to previous Civil Service Commission standards will induce retired military physicians to go to work for the Pentagon as civilian employees to help ease the shortage caused by the end of the military "doctor draft."

Chiropractors and P.T.

The government issued final regulations defining the conditions under which Medicare will help pay for services provided by independent physical therapists and limited services by chiropractors.

Under the regulations, carrying out the Medicare amendments law of last year, covered chiropractic services are limited to manual manipulation of the spine to correct "subluxations" which can be demonstrated by x-ray. Also, chiropractors must meet strict educational and professional requirements before their services can be reimbursed under the program.

The cost of x-ray will not be covered. HEW said the x-ray must demonstrate "at least . . . a malpositioning of a vertebra" identifiable by any experienced x-ray reader.

Education

The Senate Labor and Education Committee has approved a revolutionary medical education bill that would require all medical graduates to serve in shortage areas and compel relicensing of all physicians. The measure carries almost a $1 billion in federal aid for medical and other health schools over the next five years.

In addition to the controversial mandatory service and relicensing provisions, the bill gives the federal government poower to allocate and limit postgraduate training positions for physicians. Designed to curb reliance on foreign medical graduates and to increase the numbers of primary care physicians, the disputed provision also requires the Secretary of HEW to limit the number of postgraduate physician training positions to no more than 10 percent above the number of domestic medical and osteopathic school graduates that year. The HEW Secretary would assign the total number of certified positions established to the various categories of specialty and subspecialty practice of medicine.

The Association of American Medical Colleges and the AMA were sharply critical of these provisions.

Vitamins

The AMA has opposed legislation that would eliminate the authority of the FDA to control the kinds and amounts of ingredients in dietary supplements and other foods for dietary uses.

Appearing before the Senate Health Subcommittee, AMA officials noted that excessive use of vitamins can be harmful and is scientifically unwarranted. Combinations of vitamins should contain only those vitamins shown to be essential in human nutrition.

Recent FDA regulations limiting the inclusions of certain vitamins and/or minerals in dietary supplements have aroused the wrath of food-vitamin faddists and prompted introduction of legislation to overturn the FDA's actions.

Accepting the assignment

Less than half of the nation's physicians are now accepting assignment for all of their Medicare patients, according to the latest government figures. Deputy Assistant HEW Secretary Stuart Altman revealed the decline in testimony before the House Ways and Means Committee on national health insurance. HEW Secretary Caspar Weinberger later told the Committee a NHI program should carry inducements for physicians to accept the assignment route, but opposed making it mandatory.

Books

Books reviewed

Handbook of Psychiatry, edited by Philip Solomon, M.D., and Vernon D. Patch, M.D.; 706 pp.; limp cover; $8.00; Lange Medical Publications, 1974.

This is the third edition of the Handbook, which first appeared in 1969. The book is divided into 4 sections and into 40 chapters, written by 34 contributors (including the 2 authors). There are bibliographies and an index is supplied.

The book is readable, but handbooks are as large as what we used to call textbooks. Each chapter is headed by a welcome condensation; there is a genetic glossary and there are tables. I liked the chapter on History of Psychiatry.

At eight dollars, you can't refuse their offer.

—F.C.

Planning for Health, by Henrik L. Blum, M.D.; 622 pages; hard cover; $24.95; published 1974 by Human Sciences Press, 72 Fifth Avenue, New York.

The author is Professor of Health Planning in the School of Public Health and Department of City and Regional Planning at the University of California at Berkley.

Health planning has come to involve huge sums of money and has become a perplexity of government agencies and institutions, and now bewilders administrators and others concerned with health care. But heredity, environment, and behavior patterns have more influence on health, the author feels, than medical care. Broad scope planning is here more a matter of discussion than practice, he writes.

The book is divided into five parts and 12 chapters. There is a scattering of figures, many references, and a good index. Dr. Blum analyzes the various approaches to health care, and regards health planning as the vehicle for considered health-promoting social change.

It is, as you see, a large book, and not easy to read. I could not find doctor, physician, hospital, emergency, or emergency room in the index; it is that kind of book. It contains the sentence: "The medical nucleus has had, if you will, peer review of all the happenings of the health sector and has brought it to the present unwholesome mess, in great part due to medical disinterest in health and in health care."

—F.C.

Books received

Lou Torok: Straight Talk from Prison; hard cover; 142 pages; $7.95; published 1974 by Human Sciences Press, New York.

Developments in High School Psychology, edited by Harwood Fisher, Ed.D.; 292 pages; hard cover; $12.95; published 1974 by Behavioral Publications, New York.

Nutrition Reviews; Special Supplement; July 1974; paperback; 73 pages; $2.50; order from The Nutrition Foundation, Office of Education and Public Affairs, 888 Seventeenth Street, N.W., Washington, D.C.

Adolescent Patients in Transition, Impact and Outcome of Psychiatric Hospitalization; hard cover; 202 pages; $9.95; edited by Mollie C. Grob, S.M. and Judith E. Singer, Ph.D.; published 1974 by Behavior Publications, New York.

Teaching the Mentally Handicapped Child; edited by Ralph Hyatt, Ed.D., and Norma Rolnick, Ph.D.; hard cover; 337 pages; $12.95; published 1974 by Behavioral Publications, New York.

N.C.M.E.

September 23 - October 6

THERAPEUTIC ANESTHESIA FOR LOCALIZED PAIN.

PSRO: THE ISSUE OF 1974.

BODY LANGUAGE IN DIAGNOSIS.

October 7 - October 20

EARLY PROSTHETIC FITTING FOR CONGENITAL DEFECTS OF THE EXTREMITIES.

CORTICOSTEROIDS: TREATMENT FOR THREE CONNECTIVE TISSUE DISEASES.

OFFICE TREATMENT OF SKIN CANCER.

Welcome to Portland, Oregon for the 28th Clinical Convention

November 30-December 4, 1974

"In this age of specialization, there's a vital need for discussion of the broader implications of new-found knowledge. The 28th AMA Clinical is designed for that purpose...to bring together physicians of the various specialties to study and discuss the broader aspects of medicine as they apply to their practices."

Huldrick Kammer, M.D., Chairman
Council on Scientific Assembly

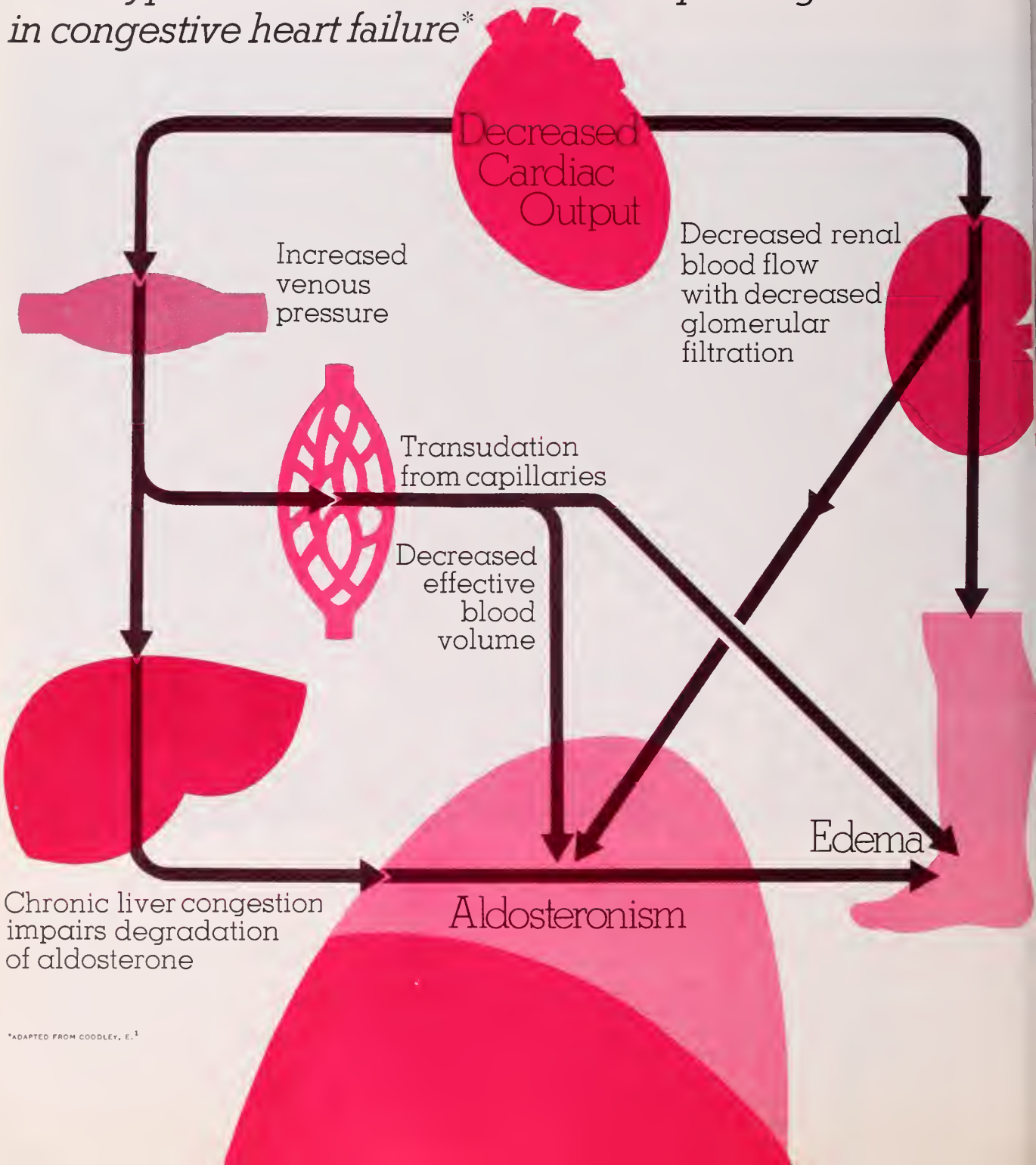
AMA
AMERICAN MEDICAL ASSOCIATION

For further details, write:
Circulation & Records Dept.
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

In congestive heart failure...

secondary aldosteronism

*How hyperaldosteronism leads to and prolongs edema in congestive heart failure**



*ADAPTED FROM COODLEY, E.[1]

s a primary factor

To "switch off" the aldosterone factor in congestive heart failure

Aldactone

rand of

spironolactone 25-mg. tablets

the only specific aldosterone antagonist... basic in all diuretic therapy

Three ways to use Aldactone in congestive heart failure

1. As the only diuretic
- Often sufficient alone.
- Produces gradual, sustained diuresis by blocking aldosterone action in the distal renal tubule.
- Avoids potassium loss.

2. As the basic daily diuretic with an "add-on" alternate-day-diuretic ("A.D.D." schedule)
- Can be administered daily as basic therapy with the additional agent (furosemide or ethacrynic acid) given every second or third day.
- Aldactone plus "A.D.D." schedule minimizes potassium deficiency and potentiates effect of "add-on" diuretic.[2]
- Avoids acute volume depletion and aldosterone rebound.[2]

3. As a daily diuretic in combination with a daily dose of a thiazide
- Permits daily additive diuretic effect while maintaining potassium balance.

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: 1. Coodley, E.: Consultant 12:106-107, 109, 111, 113, 115 (July) 1972. **2.** Thorn, G. W., and Louler, D. P.: Am. J. Med 53 673-684 (Nov.) 1972.

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San Juan, Puerto Rico 00936

Address medical inquiries to:
G. D. Searle & Co.
Medical Department
Box 5110, Chicago, Illinois 60680

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The Role of the Detail Man

Opinion & Dialogue

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.

Dr. Willard Gobbell
Family Physician
Encino, California

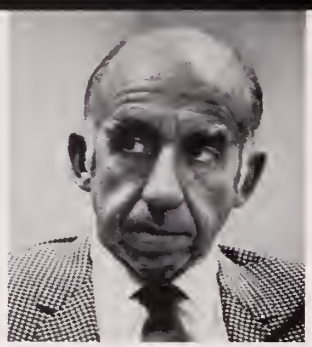
"In the total picture of dealing with health problems in this country there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

Medicinews

Medical manpower

The Senate Labor and Public Welfare Committee has ordered reported S. 3585, the Health Professions Educational Assistance Act of 1974. The bill extends authority which expired June 30 of this year for assistance to schools and students in the health professions. Presently this authority is being carried out under a continuing resolution. The bill provides loans and scholarships for students as well as various types of financial assistance to the schools including capitation payments. Included in the committee bill is a provision that schools of medicine, in order to receive capitation payments, will have to assure the Secretary that all the students of the school agree to service in an area designated by the Secretary of HEW upon completion of their training. The Secretary would then have authority to assign the number of students he deemed necessary to meet health shortage area needs. The bill also contains provisions to require national licensure and relicensure of physicians and dentists as well as provisions which would restrict the number of residencies available each year and which would give the Secretary authority to designate the number of each type of residency which should be available.

The House Subcommittee on Public Health and Environment will shortly begin mark up of a health manpower bill. At the present time no legislation before the House Subcommittee contains provisions requiring general mandatory service or licensure and relicensure. However, there are provisions before the House which are similar to those in the Senate bill restricting the number of residencies. The House Subcommittee has completed action on a nurse training bill.

Controlled substances

The House also has passed H.R. 14213, a three-year, $480 million extension of the Controlled Substances Act. Among its provisions the bill repeals the "no-knock" section of the Act. The bill also extends normal federal parole provisions to prisoners convicted and sentenced prior to May 1971 for the violation of certain drug abuse control laws which were repealed by the 1970 Act. Repeal of the controversial "no-knock" provision would end existing authorization of search warrants which allow narcotic agents to enter and search premises without advance warning. A similar Senate-passed bill, S. 3355, which provides appropriations to the Drug Enforcement Administration over a 5-year period would also repeal the present "no-knock" law.

In brief

The House has passed *H.R. 16045*, a two-year extension of the Solid Waste Disposal Act . . . The Senate Committee on Labor and Public Welfare has ordered reported *S. 3280*, the Health Services Act of 1974, extending authority under the PHS Act for aid to community mental health centers, migrant workers and neighborhood health centers . . . The House Ways and Means Committee recently opened daily mark up sessions on national health insurance. Representative Al Ullman (D., Ore.), serving as acting chairman of the Committee, called for the committee to write a new bill adopting what it considers the best features of the major national health insurance proposals pending before it . . . The House Subcommittee on Public Health and Environment has given final approval to *H.R. 16317* relating to the authority of the Secretary of HEW to regulate certain diet foods.

Medicare

HEW Secretary Caspar W. Weinberger has approved final regulations defining the conditions under which Medicare will help pay for services provided by independent physical therapists and limited services by chiropractors, and extending the authority of optometrists and dentists to certify reimburseable services under the program.

Under the regulations, which reflect the intent of legislation, covered chiropractic services are limited to manual manipulation of the spine to correct "subluxations" which can be demonstrated by x-ray. Also, chiropractors must meet strict educational and professional requirements before their services can be reimbursed under the program.

Services provided by an independent physical therapist may be covered by Part B, the medical insurance part of Medicare, when they are furnished in the therapist's office or in the patient's home, but only if the therapist meets specified professional qualifications.

A beneficiary's expenses for services provided by an independent physical therapist can be recognized up to a limit of $100 in a calendar year. If the beneficiary's medical expenses unded Part B have already exceeded the annual deuctible amount of $60, he could be reimbursed by Medicare for 80 percent, or up to $80 in a year.

An optometrist may now certify a patient's need for prosthetic lenses, and a dentist may now certify the need for hospitalization for a dental procedure, but only if the patient's medical condition prevents the procedure from being performed in a nonhospital setting. Previously, these certifications had to be made by an M.D.

Out-of-hospital prescriptions

The Social Security Administration is undertaking a study of how out-of-hospital prescription drugs might be administered under national health insurance or Medicare, James B. Cardwell, Commissioner of Social Security, announced recently.

Commissioner Cardwell announced the signing of a $559,839 contract with Paid Prescriptions of Burlingame, California, for a study of alternative insurance arrangements for out-of-hospital prescriptions. He said that the contract is part of the Social Security Administration's continuing study to assess the effects of cost-sharing on the costs of providing outpatient drug benefits.

Under the contract, Paid Prescriptions will administer out-of-hospital drug insurance programs in Sacramento and San Joaquin counties in California. Participants in this study will be selected by social security from the rolls of Medicare beneficiaries in these counties.

About 4,800 participants will be divided into four groups, each with different arrangements for cost-sharing through coinsurance and deductibles. One group will be given full drug coverage with no patient cost-sharing. The second group will pay $1 per prescription. Group three will pay a 25 percent coinsurance per prescription, while the fourth group will pay a 25 percent coinsurance per prescription after a $50 annual deductible has been met.

The latter plan is similar to the Administration's drug benefit in its proposed Comprehensive Health Insurance Plan. The other plans are similar to those most commonly proposed under other national health insurance plans. Extensive data on drug utilization and administrative costs will be gathered.

Social Security's Office of Research and Statistics is sponsoring the study and will evaluate the results. The study will take approximately 18 months to complete.

National health insurance

Representative Wilbur D. Mills (D., Ark.), Chairman of the House Ways and Means Committee has now proposed a broad outline of a compromise national health insurance bill. The proposal followed the request by President Ford for passage of national health insurance during this year. Following the announcement the President met with Chairman Mills and Chairman Russell B. Long (D., La.), of the Senate Finance Committee to discuss national health insurance and trade reform legislation. Under the Mills proposal there would be a federally financed program of health care for the poor. The program would have uniform eligibility requirements and benefits for all poor individuals across the nation. However, it is expected that the program would be administered by the states. Coverage for the costs of catastrophic illness under the proposal

would be financed by a payroll tax requiring employers to pay up to 75% and workers 25% of the costs for catastrophic coverage. A third feature of the proposal is mandated, phased-in health insurance providing basic health insurance benefits. Employers and employees would contribute toward the costs of this coverage and would be able to deduct premium costs from their income taxes. There would be a standard minimum benefit package which has not yet been determined and a maximum amount of coverage (presently expected to be about $5,000) which would have to be provided at which point catastrophic illness coverage would begin. It is expected that the basic coverage for employers and employees would be provided by private insurance on an underwriting basis, but it is not known whether the catastrophic provisions would be administered by private insurance or by the Social Security Administration. Mr. Mills indicated that he wanted a draft of the proposal to be available to the Committee members before the Labor Day recess which began on August 22. He further predicted that the House would pass an NHI bill by October 1st.

Food supplements

C. E. Butterworth, Jr., M.D., Chairman of the AMA Council on Foods and Nutrition together with Vice Chairman Theodore B. Van Itallie, M.D., appeared on behalf of the AMA to discuss the Food Supplement Amendments, S. 2801. The bill pending before the Senate Health Subcommittee would restrict the authority of the FDA with respect to food supplements. Recent FDA regulations have limited the inclusion of certain vitamins and/or minerals in products to be marketed as dietary supplements. The FDA has announced further regulations based upon levels of Recommended Dietary Allowances established by the National Academy of Sciences. The AMA spokesmen noted that excessive use of vitamins can be harmful and that such dietary regimen is scientifically unwarranted. It was emphasized that combinations of vitamins should contain only those vitamins shown to be essential in human nutrition or metabolism. With respect to the quantities of vitamins included in dietary supplements, the Association said "There is no valid evidence to demonstrate that larger amounts of nutrients are beneficial under ordinary physiological conditions. In fact, an overdose of vitamins A and D can be harmful, if taken over a prolonged period of time." Accordingly, the Association opposed legislation which would eliminate the authority of the Secretary to control the kinds and amounts of ingredients in dietary supplements and other foods for dietary use.

Retirement income

The final conference report has been issued on H.R. 2, the Employee Benefit Security Act of 1974. Included in this conference report are amendments to the Keogh retirement program which allow deductions of 15% of income or $7,500, whichever is less, to be set aside for retirement purposes. Individuals participating in professional service corporations would be allowed to set aside an amount which will result in a pension equal to $75,000 per year or 100% of the participant's average compensation for his high three years of income, whichever is lower. House and Senate action on the conference report is expected quickly.

Health care planning

The House Committee on Interstate and Foreign Commerce has begun its consideration of H.R. 16204, the National Health Policy, Planning, and Resources Development Act of 1974. The bill, as drafted by the Subcommittee on Public Health and Environment, would establish a regulatory program of planning and resource development to replace CHP and RMP. A 15-member National Council for Health Policy would develop guidelines and conduct studies regarding health care issues. Health Systems Agencies (HSA's) would be established in designated health areas throughout the United States. The HSA's would be nonprofit private corporations with a governing board of 10 to 30 members, a majority of whom were consumers. These agencies

would develop health systems plans annually as well as annual implementation plans describing the manner in which the stated goals were to be achieved. State Health Planning and Development Agencies would review the need for institutional health services setting standards for facilities and manpower, review the quality of services, license health care facilities and health manpower and otherwise regulate the health care delivery system. The Committee will continue its review of this bill after the Labor Day recess.

National health insurance

The House Committee on Ways and Means, after conducting more than a week of sessions directed toward developing a compromise NHI bill, has now deferred action on the subject. It appears certain that no such legislation will be passed in the present Congress, although the Committee staff has been instructed to continue its efforts to formulate alternative health insurance provisions to be considered by the Committee. Votes were taken during the week on several major policy questions, but apparently the Committee was unable to agree upon a mutually acceptable financing plan for catastrophic health insurance. Chairman Wilbur D. Mills (D., Ark.) had presented a 12-page proposal to the Committee in which he outlined major principles as well as certain specifics of a national health insurance program. The proposal formed the basis for the Committee discussion and for the several votes which were taken. Representative Broyhill (R., Va.) called for the adoption of the tax credit financing system as embodied in the AMA's Medicredit proposal, but the motion failed to carry as a result of a 12-12 tie. Also defeated by a vote of 13-12 was a proposal to adopt the financing system of H.R. 5200, the NHI proposal advanced by the Health Insurance Association of America. The Committee did, however, agree to a proposal for standardizing the Medicaid program. It was apparent from the voting that the Committee had not reached agreement on major elements of a national health insurance plan. After announcing the postponement of further consideration of NHI, Chairman Mills stated that it was still possible to develop an acceptable program this year but that such progress would require a great deal of compromise within the Committee. He further noted that the Committee must consider major tax legislation prior to adjournment.

The proposal, developed by staff at the direction of Representative Mills, would provide the following: (1) coverage of the expenses of catastrophic illness financed by a payroll tax requiring employers to pay up to 75% and workers up to 25%; (2) uniform eligibility requirements and benefit structures for the Medicaid plan; and (3) mandated employer-employee health insurance for the first $6000 of cost incurred per family per year. The employer would contribute at least 75% of the health insurance premium under the mandated plan (65% for the first three years of the program). An alternate plan would be established to cover those persons not otherwise insured. The plan would be administered through the states through a state chartered health insurance corporation. The Medicare program would be revised to remove the limits on hospital days, limit deductibles and coinsurance to $1,000 and provide coverage of outpatient drugs.

Health revenue sharing

By a vote of 359 to 12, the House has passed H.R. 14214, the Health Revenue Sharing and Health Services Act of 1974, a two-year extension of five programs for health services which expired June 30 of this year. Total authorization for the five programs is $1.7 billion. The programs to be extended include support for community mental health centers, migrant health, family planning, community health centers and a health revenue sharing program which provides money for state and local communities to help pay their costs in providing public health services. A similar bill has already passed the Senate.

Congress adopts pension reform

The Employee Benefit Security Act, H.R. 2, passed both Houses of Congress this week

and will now be sent to the President who is expected to sign the legislation. The bill, which is intended to strengthen the protection of 35 to 40 million persons contributing to private pension plans, would, among other things, increase the allowable contribution which self-employed individuals may make to a Keogh plan. The newly adopted legislation would allow such individuals to contribute 15% of income to a maximum of $7500 annually, whichever is less. Individuals participating in professional corporations would be allowed to set aside an amount which will result in a pension equal to $75,000 per year or 100% of the participant's average compensation for his high three years of income, whichever is lower.

Treatment of Asthma With Triamcinolone Acetonide Delivered by Aerosol — M. H. Williams, Jr., et al (Albert Einstein College of Medicine, Bronx, NY 10461). Am Rev Respir Dis 109:538-543 (May) 1974.

Twenty-one patients with steroid-dependent asthma were treated by inhalation of 0.8 mg/day of triamcinolone acetonide. Nineteen patients reported substantial symptomatic improvement despite reduction of the oral dose of steroids, and in 16, orally given steroids were discontinued entirely. Twelve of the patients measured peak expiratory flow rates (PEFR) four times per day before and during therapy, and the average of each of the four measurements was higher during the first one to two weeks of treatment than during a similar period of placebo administration. Double-blind crossover trial was performed in 12 patients, eight of whom were taking a constant dose of prednisone throughout the study. Eleven patients reported symptomatic improvement while receiving active drug, and in nine, PEFR was significantly higher. For the group as a whole, PEFR was higher while receiving drug than while receiving placebo ($P<0.001$). Thirty-four patients were were treated with triamcinolone acetonide for from 3 to 12 months. Of 32 patients who have required steroids, 23 have been maintained exclusively on triamcinolone acetonide, 6 have required brief periods of supplemental prednisone, and 3 have been maintained on smaller doses of prednisone. Side effects have been minimized to transient hoarseness and change of voice. Several patients have reported symptoms of adrenal insufficiency during tapering of prednisone dosage, and others have had disappearance of Cushingoid symptoms as well as improvement of asthma. Inhalation of small doses of triamcinolone acetonide does not appear to produce the side effects induced by other corticosteroids.

Inhibition of Nocturnal Acid Secretion in Duodenal Ulcer by One Oral Dose of Metiamide — G. J. Milton-Thompson et al (J. J. Misiewicz, Central Middlesex Hosp, London). Lanset 1:693-694 (April 20) 1974.

The effect on nocturnal acid secretion of a single oral dose of metiamide, 400 mg, taken on retiring was studied in 11 men with duodenal ulcer. Ten of them responded to the drug with a striking and highly significant reduction of acid output and rise in pH of gastric contents. Eight patients were rendered anacidic for varying periods of time after the drug. There were no unwanted effects.

Iatrogenic Perforations of Esophagus: Therapeutic Considerations — Y. Wooloch et al (Beilinson Hosp, Petah-Tiqva, Israel). Arch Surg 108:357-360 (March) 1974.

Iatrogenic perforation of the esophagus was diagnosed in nine patients. Seven were operated on and all survived even when operation was delayed for as long as 48 to 72 hours. Both of the patients who were treated conservatively died, despite the fact that treatment was commenced immediately after the perforation had occurred. Surgical treatment is indicated in all cases of esophageal perforation and conservative management should be employed only in those patients whose general condition does not permit operation.

Death at the Wheel: Consideration of Cardiovascular Disease as Contributory Factor to Road Accidents — D. W. Hossack (70 Collins St, Melbourne). Med J Aust 1:164-166 (Feb 9) 1974.

Of 102 drivers who died at the wheel of their cars, 11 had died of natural causes. Five of these drivers were able to stop the car before death, and the other six drivers had accidents of a minor nature not involving injury to others and received only insignificant injuries themselves.

Blood Pressure in Women Taking Oral Contraceptives — R. J. Weir et al (Western Infirmary, Glasgow, Scotland). Br Med J 1:533-534 (March 23) 1974.

A controlled prospective survey of women taking estrogen-progestogen oral contraceptives has shown increases in mean systolic and diastolic blood pressure of 14.2 mm Hg and 8.5 mm Hg, respectively, after four years. The largest increase in individual cases were 36 mm Hg systolic and 20 mm Hg diastolic. The highest systolic pressure reached was 155 mm Hg; diastolic pressure did not exceed 90 mm Hg in any subject. Blood pressure returned to pretreatment levels within three months after oral contraceptives had been stopped. These changes in blood pressure were not related to the progestogenic potencies of the preparations being used.

Salt-Poor Human Albumin in Management of Nephrotic Syndrome — A. M. Davison et al (Royal Infirmary, Edinburgh). Br Med J 1:481-484 (March 16) 1974.

Twelve patients with nephrotic syndrome were treated with a high protein diet, 1.3 gm sodium chloride intake, and frusemide in increasing doses. One patient became free of edema with 240 mg daily of frusemide, three with 300 mg daily, and two required combined high-dose frusemide and spironolactone. Of the remaining six patients, two failed to lose weight, three had significant increases in blood urea, and one had hyponatremia. Infusions of salt-poor albumin with continued diuretic administration induced a prompt diuresis, loss of weight, and correction of abnormal biochemical findings in all six patients.

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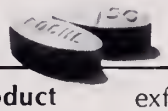

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For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

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in psychoneurotic anxiety states with associated depressive symptoms

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Manuscripts to be presented for publication in the JOURNAL should be typewritten, double-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title-page should be shown the title of the article, the name (or names) of the author, his degree and other significant credits. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Illustrations should be numbered and their locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be in black (India ink) on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

Manuscripts (original, not a carbon) should be sent directly to the Editor at the Journal's address.

Letters to the Editor submitted for publication should be prepared as above, and must carry the notation: To be Published.

Reprints should be ordered from the printer, Norfolk Printing Co., Inc., P. O. Box 278, Norfolk, Nebr. 68701.

Medicinews . . .

Planning bill ordered reported

The House Committee on Interstate and Foreign Commerce has ordered reported H.R. 16204, the National Health Policy Planning and Resources Development Act of 1974. The bill would establish a National Council for Health Policy which would be responsible for the development of guidelines respecting the appropriate supply, distribution and organization of health resources and services. A system of Health Systems Agencies would be established throughout the nation to develop Health Services Plan for their respective areas. In addition, each HSA would be responsible for developing an Annual Implementation Plan setting forth the specific methods through which the long term goals would be achieved. HSA's would make recommendations to state agencies regarding the need for proposed institutional services as well as the need for existing services. The State Health Planning and Development Agencies created under the bill which would carry out the planning activities for the state and enforce specified certificate of need or similar legislation. The bill would phase-out CHP and RMP, and it would replace the Hill-Burton program with a new system for health resources development.

OWNERSHIP, MANAGEMENT AND CIRCULATION STATEMENT

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"Gentlemen, congratulations are in order."

"A.H. Robins asked me compare the banana flavor of their onnagel® -PG with the real thing and, y jove, I couldn't tell the difference. ot even in sip-by-sip comparison. mazing!

"There's no unpleasant aregoric taste because there's no aregoric. Clever, wouldn't you say? stead, A. H. Robins uses the thera- eutic equivalent, powdered opium, promote the production of formed stools and lessen the urge. And Donnagel-PG also provides the demulcent-detoxicant effects of kaolin and pectin, plus the antispasmodic benefits of belladonna alkaloids.

"But what I find most impressive is the skillful manner in which A. H. Robins has combined these ingredients with that delicate flavor of vintage bananas. Smashing, absolutely smashing!

"May I propose a toast?"

Donnagel®-PG. ℞

Donnagel with paregoric equivalent
Each 30 cc. contains:

Kaolin	6.0 g
Pectin	142.8 mg
Hyoscyamine sulfate	0.1037 mg
Atropine sulfate	0.0194 mg
Hyoscine hydrobromide	0.0065 mg
Powdered opium, USP	24.0 mg
(equivalent to paregoric 6 ml.) (warning may be habit forming)	
Sodium benzoate (preservative)	60.0 mg.
Alcohol, 5%	

℞ Available on oral prescription or without prescription in compliance with applicable state and local law

A·H·ROBINS

A. H. Robins Company, Richmond, Virginia 23220

Robitussin
Robitussin-DM
Cough Calmers

A·H·ROBINS

IN COUGHS OF COLDS, 'FLU, AND U.R.I.: CLEAR THE TRACT WITH THE ROBITUSSIN® LINE

Fall and winter coughs are back. Time to help clear the lower respiratory tract with the five Robitussins and Cough Calmers. All contain glyceryl guaiacolate, the efficient expectorant that works systemically to help increase the output of lower respiratory tract fluid. The enhanced flow of less viscid secretions soothes the tracheobronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise. Available on your prescription or recommendation.

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Each 5 cc. contains:
Glyceryl guaiacolate ..... 100 mg.
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Each 5 cc. contains:
Glyceryl guaiacolate ..... 100 mg.
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(warning: may be habit forming)
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Non-narcotic for 6-8 hr. cough control

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Each 5 cc. contains:
Glyceryl guaiacolate ..... 100 mg.
Dextromethorphan hydrobromide ..... 15 mg.
Alcohol, 1.4%

Robitussin-DM in solid form for "coughs on the go"

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Each Cough Calmer contains:
Glyceryl guaiacolate ..... 50 mg.
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Clears nasal and sinus passages as it relieves coughs

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Each 5 cc. contains:
Glyceryl guaiacolate ..... 100 mg.
Phenylephrine hydrochloride ..... 10 mg.
Alcohol, 1.4%

MEET THE NEWEST MEMBER OF THE LINE

Comprehensive decongestant action helps control cough and clear stuffy nose and sinuses. Non-narcotic.

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Each 5 cc. contains:
Glyceryl guaiacolate ..... 50 mg.
Dextromethorphan hydrobromide ..... 10.0 mg.
Phenylpropanolamine hydrochloride ..... 12.5 mg.
Alcohol, 1.4%

Select the Robitussin® formulation that treats your patient's individual coughing needs:

	Expectorant-Demulcent	Cough Suppressant	Long-Acting (6-8 hours)	Nasal, Sinus Decongestant	Non-Narcotic
ROBITUSSIN®	●				●
ROBITUSSIN A-C®	●	●			
ROBITUSSIN-DM®	●	●	●		●
ROBITUSSIN-PE®	●			●	●
ROBITUSSIN®-CF	●	●		●	●
COUGH CALMERS®	■	■	■		■

A. H. Robins Company, Richmond, Va. 23220

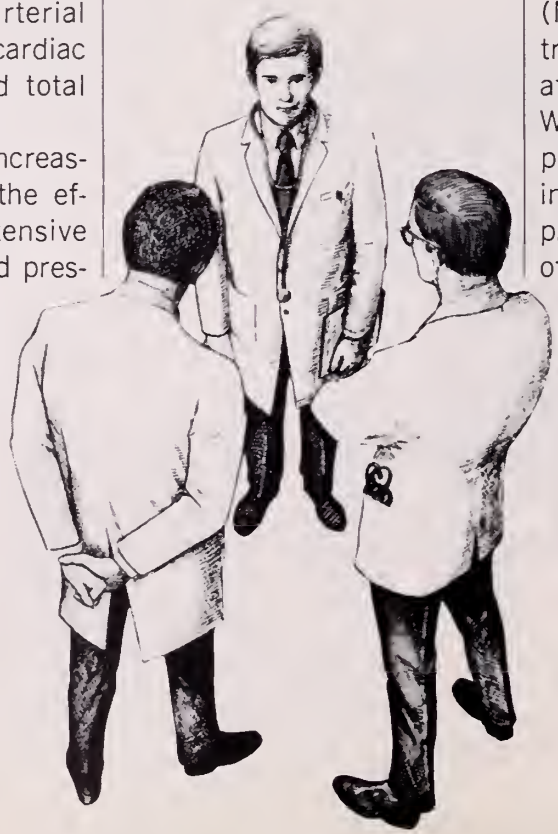
The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

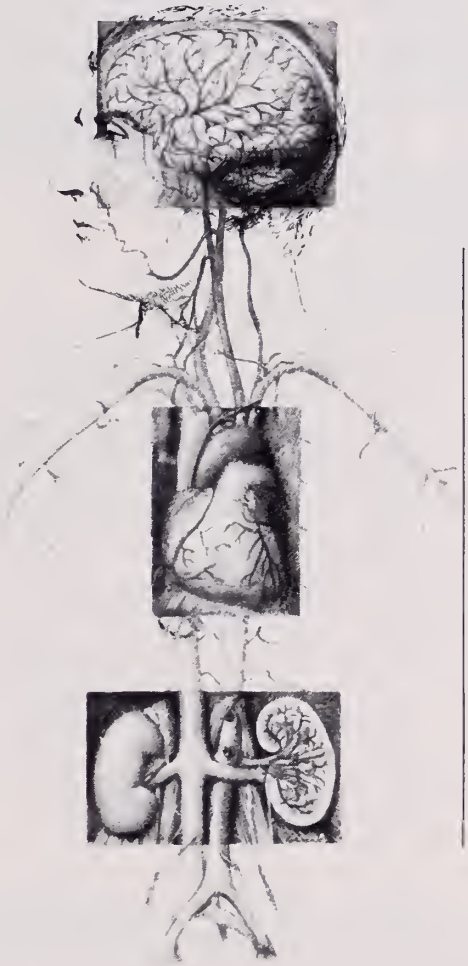
And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?

With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in



the more physicians rely on this unique antihypertensive



lowering blood pressure. But there are other considerations as well. Cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is actually slowed. Peripheral resistance is apparently reduced. ALDOMET does not usually compromise existing renal function; it generally does not reduce renal blood flow, glomerular filtration rate, or filtration fraction. And ALDOMET usually does not cause symptomatic postural or exercise hypotension.

Contraindications include active hepatic disease and known sensitivity to the drug. Use with caution in patients with a history of liver disease or dysfunction. Not recommended in pheochromocytoma or pregnancy.

It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

In most cases of sustained moderate hypertension

TABLETS, 250 mg and 500 mg

ALDOMET®

(METHYLDOPA | MSD)

smoothly lowers blood pressure

NEW now available in **500 mg TABLETS** as well as the standard 250-mg tablets

For a brief summary of prescribing information, please see following page.

In most cases of sustained moderate hypertension

ALDOMET® (METHYLDOPA MSD)

smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis. Known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between six and twelve months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at six and twelve months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first six to twelve weeks of therapy or whenever an unexplained fever occurs. If fever, abnormalities in liver function tests, or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur.

Use in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Methyldopa may interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure are occasionally seen and include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Angina pectoris may be aggravated. Symptoms of orthostatic hypotension may occur; if symptoms occur, reduction of dosage is suggested. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distention, constipation, flatus, and diarrhea occur occasionally; these generally can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently and are relieved by administering a thiazide diuretic; if edema progresses or signs of pulmonary congestion appear, discontinue drug. A rise in BUN has been observed. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, Bell's palsy, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Note: Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Maximal recommended daily dose is 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

How Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

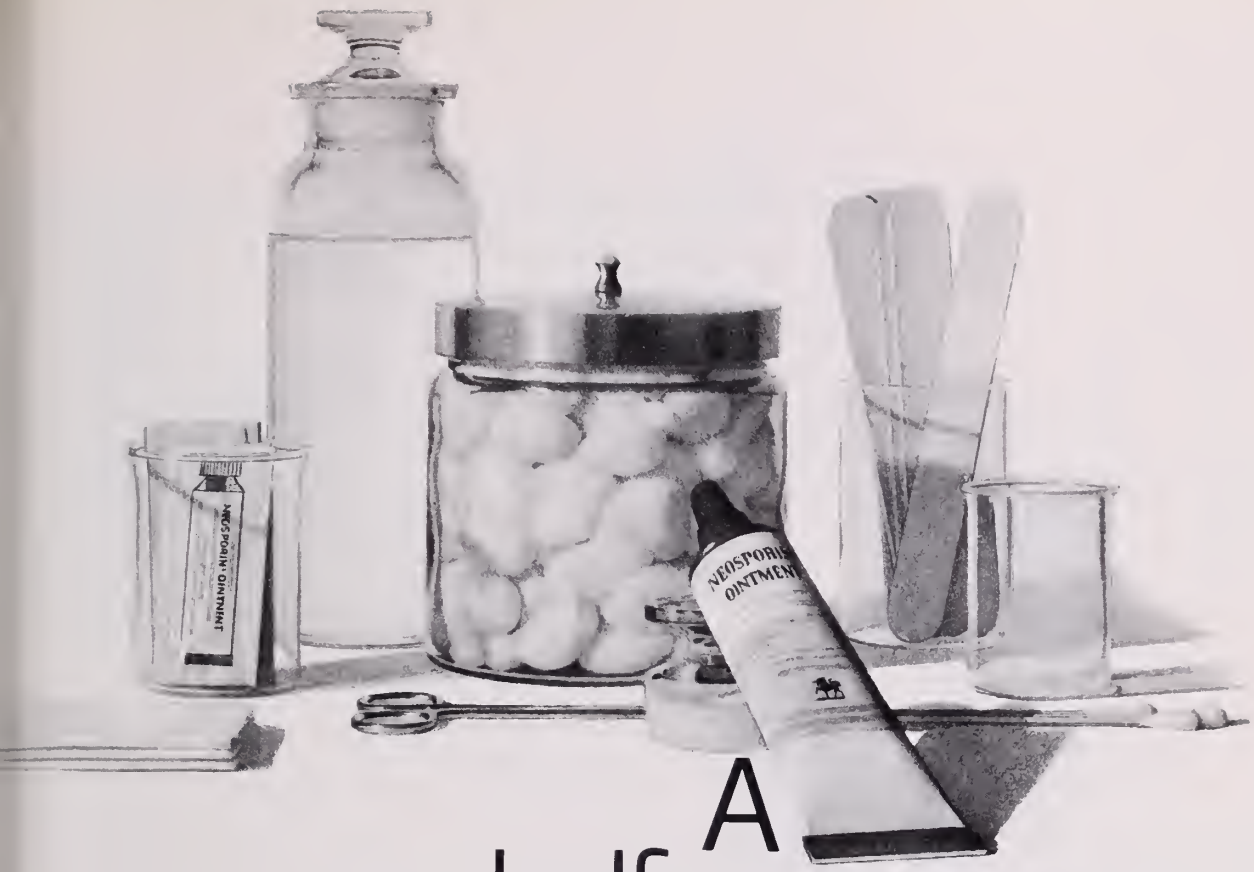
addendum

MSD
MERCK
SHARP
DOHME

"Required Reading" For Your Hypertensive Patients

Because of the importance of patient motivation, Merck Sharp & Dohme offers "High Blood Pressure," a concise, pocket-sized booklet that defines the patient's own role in the management of hypertension. This booklet is available for you to give to your patients. It is designed to reinforce your explanation of hypertension and it emphasizes the importance of patient understanding in adhering to the regimen you prescribe.

Please ask your Merck Sharp & Dohme Professional Representative or write Professional Service Department, West Point, Pa. 19486 for a supply of this booklet.



A half-ounce of prevention

Use it to prevent a topical infection. Or to treat one that's already started. In either case, it's good medicine. Whether for lacerations, burns, open wounds, IV catheter or surgical aftercare. Neosporin® Ointment provides broad antibacterial coverage against common susceptible pathogens. And since it contains three antibiotics that are rarely used systemically, the risk of sensitization is reduced. Neosporin Ointment. A half-ounce of prevention. Also available in a full ounce of prevention and in convenient foil packets.

Neosporin Ointment carried on Apollo and Skylab missions.

Neosporin® Ointment
(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs.
In tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

CATIONS: *Therapeutically,* used as an adjunct to appropriate systemic apy for topical infections, primary or secondary, due to susceptible organ-, as in: • infected burns, skin grafts, surgical incisions, otitis externa mary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • second-ly infected dermatoses (eczema, herpes, and seborrheic dermatitis) umatic lesions, inflamed or suppurating as a result of bacterial infection. *ophylactically,* the ointment may be used to prevent bacterial contamination rns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts wounds accidentally incurred, its use may prevent the development of ction and permit wound healing.

TRAINDICATIONS: Not for use in the eyes or external ear canal if the eardrum rforated. This product is contraindicated in those individuals who have n hypersensitivity to any of the components.

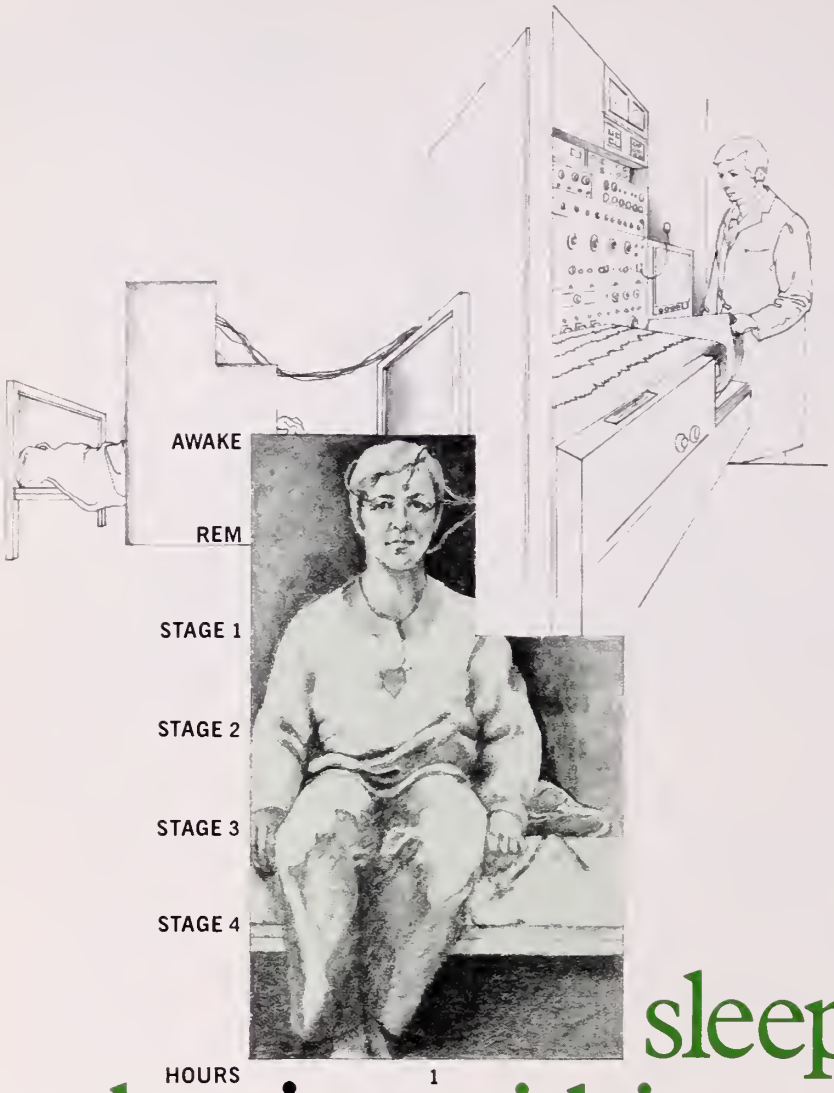
NING: Because of the potential hazard of nephrotoxicity and ototoxicity to neomycin, care should be exercised when using this product in treating nsive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Wellcome / **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709



sleep begins within 17 minutes, on average...

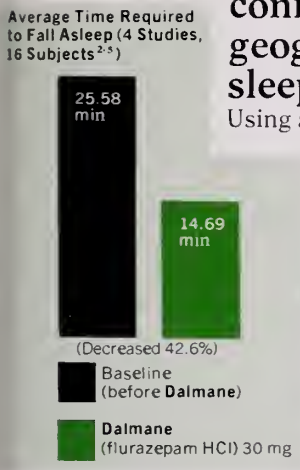
an initial benefit of

Dalmane®

(flurazepam HCl)

proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.
Contraindications: Known hypersensitivity to flurazepam HCl.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

when restful sleep is indicated

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- sustains sleep 7 to 8 hours, on average, without repeating dosage

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry* 23:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

The Role of the Detail Man

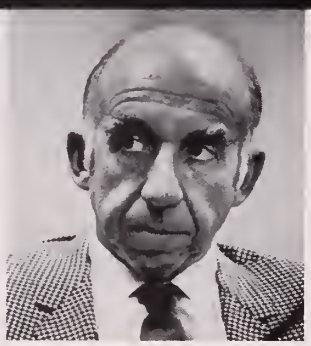
Opinion & Dialogue

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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Dr. Perry named

Dr. Perry Rigby has been named Dean of of the University of Nebraska College of Medicine in Omaha.

A faculty member at Nebraska since 1964, Dr. Rigby was made associate dean for academic affairs in 1972. He was assistant dean for curriculum since late 1971. In 1969 he was made a professor of medicine. He was appointed director of the new division of hematology in 1968.

Dr. Rigby was named a Markle Scholar in Academic Medicine in 1965.

Continuing education at Creighton

The Creighton University School of Medicine Department of Pediatrics will present a continuing education course for family physicians and pediatricians in Omaha December 6 and 7. The course will explore upper and lower respiratory tract diseases in children. The program is acceptable for six prescribed hours by the American Academy of Family Physicians. For further information you are asked to contact: Coordinator for Continuing Education, Medical Dean's Office, Creighton University, 2500 California Street, Omaha, Nebraska 68178.

Dr. Davis heads hematology at U. of N.

Dr. Richard B. Davis has been named acting director of the hematology division of the University of Nebraska Medical Center.

A native of Iowa, Dr. Davis is a professor in the department of internal medicine. He has been on the Nebraska faculty five years.

He has held appointments at the University of Minnesota and the Sir William Dunn School of Pathology in Oxford, England.

He received the Borden Award for Research, a U.S.P.H.S. Research Career Development Award and was a Research Fellow from the American College of Physicians.

He has published more than 50 publications in scientific journals.

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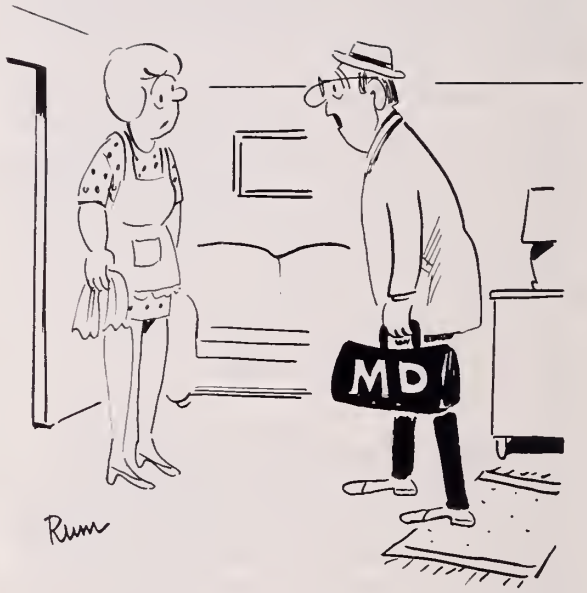

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THE NEBRASKA MEDICAL JOURNAL

ON STAMPING OUT DISEASE

Diseases come, but they go, too. It may be that more come than go, and we are left with a longer list. Appendicitis came and typhilitis went, infarction came and indigestion went; but radiation sickness, transplant rejection, decompression sickness, and transfusion reaction replaced nothing. Phthisis became TB, shaking palsy became Parkinson's disease, Graves' disease is exophthalmic goiter, Osler's disease was changed to polycythemia, and pernicious anemia was once idiopathic anemia.

Even nondoctors say menopause for change of life, schizophrenia for dementia praecox, and Down's syndrome for mongolism.

But some diseases have suffered their own mortality rate and have simply disappeared. We do not see smallpox here, nor typhoid fever, nor do we encounter polio (formerly infantile paralysis and poliomyelitis) often. But whatever happened to neurocirculatory asthenia, and what became of shell shock, and what did we do with lumbago? I suspect that they have gone the way of status thymicolymphaticus and primary syncope, and will some day be included in a list of diseases that never existed. Eliminating a disease by medical progress is one thing, but finding that there just never was such a disease is something else.

Perhaps we have such diseases today, and have yet to remove them from our lists. There is pomposity and overlapping, we have bronchial asthma and asthmatic bronchitis and asthma and bronchitis, and emphysema and obstructive lung disease. But remember how certain we were of irritable heart and of status lymphaticus, and of status periculosis and asystole. Asystole got changed to cardiac standstill and then to cardiac arrest, and I say again and again that there is no such disease as cardiac arrest.

We get rid of some illnesses by changing their names, like anasarca, bulimia, and zona; of others, by curing them, like smallpox; and of still more by realizing that they never existed.

F.C.

DON'T DO THAT

One of the oldest medical jokes I know is about the patient who said "It hurts when I do that." And the doctor said, "Don't do that."

Life is filled with things we must not do, and if you are lucky you find more dos than don'ts.

Don't ask a dog to hold a bone.

Don't ask a surgeon if you need an operation.

Don't ask the government if a drug that helps people helps people.

Don't ask the patient which drug you should use.

Don't ask the insurance company about fees.

Don't ask the anesthesiologist what he's using.

Don't ask a goat to watch the cabbage patch.

Don't ask the pathologist if he's sure.

Don't ask the radiologist why he sees what you don't see.

Don't ask the administrator why occupancy is low.

Don't ask a barber if you need a haircut.

Don't ask the pharmacist why drugs cost so much.

Don't ask the surgeon what anesthetic to give.

Don't ask the tailor if you need a new suit.

Don't be afraid to talk to the patient.

Do listen.

F.C.

ON MEASURING THINGS THAT CAN'T BE MEASURED

Counting is good, if you haven't measured a thing, you don't understand it. But you can't measure nausea, much as you want to; it is almost impossible to count vomiting. If some patients like a new drug, can you measure their acceptance on a one-to-four scale? You are apt to fail, while you are reporting success in a naive publication to a gullible reader.

Can you measure fatigue, or malaise, or headache? You can quantify mineral hardness and earthquakes and winds and rain, but what of depression, and insomnia, and tinnitus?

I have seen too many 30-case series telling you how people like hospital food, or how well toothpaste whitens their teeth, or some such imponderable they are pondering. Give up, I say.

F.C.

THE MEETING

We had the Fall Session of the NMA in Lincoln this year, from October 3rd through the 5th. I visited with the Board of Councilors and the House of Delegates and with the reference committees. I listened to our medical school Deans and to Dr. Smith, and I heard Dr. Gilligan speak.

We discussed antabuse, PSRO, HMO, and Blue Shield. I saw our student representatives. We changed antinatal to antenatal, which is just as well; and rational norms to national norms, which may not be the same thing.

Informed consent came up, and medicolegal education, and HMP. And most of the delegates wore red on Saturday; it helped.

F.C.

THE STERISKA OR THE BACKWARD ASTERISK

I commonly read magazines and even newspapers from the back to the front. The pages turn more easily that way, and it may have something to do with my reaching for the funnies first as a child. It is even so with footnotes, daggers, and asterisks.

When I see an interesting footnote, and they are all interesting, I want to read the very part of the text to which it refers. And usually I cannot find it, or if I do, it takes too long.

I have the feeling that many readers turn pages backward. And hunting through the body of the text for the elusive little asterisk when you have read the fascinating words at the bottom of the page, but do not know what they mean, is, I do believe, a failing shared by many, like crumbling crackers in your soup, or dunking doughnuts.

Because I have invented a backward asterisk, to be known as the steriska or the Cole sign. It will lead you to line 6 of the second paragraph, or something like that. I leave the details to the tailors and the carpenters, as Einstein said.

Anyway, I know a very funny unprintable story about the asterisk.

F.C.

THE CONSPIRACY

There is a conspiracy in nature to keep us from knowing more than is good for us, and to thwart us at every turn. Relativists postulated the existence of such a conspiracy after the negative result of the Michelson-Morley experiment, and concluded that it was impossible for us to know where we were, and that we could never find out.

The plot extends to other areas of our lives. Coins roll away from you and under beds, books fall the wrong way, drape drawstrings give you less than half a chance of choosing right, and you always turn past the page you want. Bread falls butter-side down, finesses don't work, and traffic lights turn red as though they were waiting for you.

Do not bulbs burn out when stores are closed, and automobile engines fail only when mechanics have gone home; do not faucets leak on weekends, and is it not true that television stops when the game starts?

Paranoia may be only a veil to hide the conspiracy, and to suggest that the fault lies in ourselves, when the world about us is perverse. Air conditioners work flawlessly in the winter, but not in July. I'd have the stars shine at noon, when we're up and can see them, and make it snow in the summer, when we can take care of it.

I wouldn't let keys get lost, typewriters spell badly, or telephones ring wrong numbers. Meanwhile, pencil sharpeners break when pencil points break, the last bus leaves five minutes before you get there, and alarm clocks fail only when you have an important date. Doors shut in your face, windshield wipers stop when it rains, and it snows on Sunday, when you would have got the day off anyway.

I am happy to expose this conspiracy; it is real and it can be terrifying. Perhaps some things are not really unknowable, and if we see that the odds are stacked against us, we may yet pierce the veil.

F.C.

ON TIME

I am down to five chronometers now,* one each in my bedroom, kitchen, and living room, on my wrist, and in the automobile. Twice a year I would go through the idiotic pretense that it was formerly noon when the sun was overhead but now it is eleven, or that it used to be eleven but it has now become twelve.

And I got to change my watch and clocks. Once a year they would advance, and six months later retard, like the minds of the inventors of this blight. So when baseball starts I turn them an hour ahead, and in football season they go ahead eleven hours, because I was once told that it is unhealthy to turn watch hands back.

I have noticed that when you bring your car into a garage to have its fuel pump replaced, the clock stops working. And turning a car's hands is wearisome.

I have done a great deal of research in connection with the problem of chronometer hands and daylight saving time, which does not save daylight, because there's the same amount of daylight, no matter what you do, and if you want to get up earlier, get up earlier. And besides, the days are shorter in the winter, and that's when we ought to get up early, and if you are going to inflict DST on people, do it in the winter. The whole thing is a little silly, and we were about to have it all year long, which is unbelievable.

F.C.

*—Six, I found one on my stove.**

**—Seven; one in the bathroom.

THREE-DIMENSIONAL PICTURES

There's no such thing.

When you look at a medical photograph on a flat page, you are seeing a two-dimensional view or reproduction of something that has three dimensions. But no matter how good it may be, a picture has only two dimensions.

Three-dimentional things are called statues.

F.C.

Zollinger - Ellison Syndrome: Clinical Features and Long-Term Follow-up — A. J. Cameron (Mayo Clinic, Rochester, MN 55901) and H. N. Hoffman II. Mayo Clin Proc 49:44-51 (Jan) 1974.

Of 26 patients with Zollinger-Ellison syndrome, all met predefined criteria for gastric hypersecretion, 17 had proved islet-cell tumor originating in the pancreas or duodenum, and three patients also had multiple endocrine adenomatosis. Clinical features included intractable peptic ulceration that was often atypically located in distal duodenum, or jejunum, diarrhea with steatorrhea, and water and electrolyte depletion resulting from loss of gastric content by vomiting or aspiration. In most patients the islet-cell tumor was malignant, or arose from multiple primary sites. Total gastrectomy was the treatment of choice.

Physical Signs and the Bedside Diagnosis of Ischemic Heart Disease

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IT is generally accepted that the diagnosis of ischemic heart disease is best made by taking a detailed history from the patient. However, at times the history is indecisive, leading to an elaborate workup, including coronary angiography. The diagnosis of angina pectoris is often missed when its description is not classic. This can occur when: (1) Pain is in an unusual location (over the posterior cervical spine, in the shoulder, under the wrist watch). (2) Pain has an unusual quality (appearing as a fullness or bloating and equated with indigestion or difficulty in breathing) (3) Pain is unrelated to effort. (4) Pain fails to respond to nitroglycerine. These nonclassical features of angina are fairly common, especially when unstable angina pectoris or impending infarction is present.

Since Heberden's classic description of this disorder over 200 years ago, the accuracy of the symptomatology has not been improved upon, despite the fact that Heberden had no knowledge of the anatomic or physiologic basis for the disease. In the past the value of the physical examination has been underestimated. Recently, there has been an increased awareness of the diagnostic value of certain physical signs of ischemic heart disease. For the purpose of this discussion, this paper is divided into physical findings of predisposing risk factors associated with ischemic heart disease, physical findings in an attack of angina pectoris, and the physical findings associated with myocardial infarction.

Physical Findings Associated With Risk Factors

It is important to evaluate the patient for predisposing factors to coronary artery disease, particularly taking note of the following: (1) *Sex.* It is distinctly uncommon to find ischemic heart disease in the premenopausal female without underlying hypertension, aortic valvular disease, diabetes, or hyperlipidemia. (2) *Body build.* Obesity only slightly increases the risk of ischemic heart disease and only when total body weight is 30-40% above standard normal for age and height. (3) *Persistent systemic arterial hyptertension.* There is a 3 to 5-fold increase in coronary artery disease in hypertensive individuals. Hypertension should be sought by blood pressure determinations as well as by funduscopic examination. (4) *Pseudoxanthoma elasticum.* This finding is noted especially in certain skin folds such as the axillae and over the neck where the skin typically reveals coarse pores and thickened skin. It has been characterized as resembling the skin of a plucked chicken. The fundi in this entity characteristically demonstrate angioid streaks. (5) *Cigarette smoking.* Nicotine staining on the index and middle finger of either hand is a valuable sign. The risk of sudden death due to infarction is much higher than in nonsmokers. (6) *Xanthomata.* These characterize the patient as having a disturbance in the lipoproteins, especially type II. They are usually found in tendinous areas (xanthoma), as well as in the soft tissues under the eyes (xanthelasma). Lipemia retinalis should also be searched for. (7) *Diabetes mellitus.* It has been said that approximately one half of all diabetics die of ischemic heart disease. Microaneurysms in the eyegrounds as well as necrobiosis diabeticorum over the lower extremities may be the first clue to this metabolic abnormality. (8) *Polycythemia.* This disorder is associated with an increased risk of coronary artery disease as well as

peripheral vascular disease and pulmonary emboli. (9) Arteritis. The first clue may well be heralded by infarction of finger or toe.

Physical Findings in Angina Pectoris

In general, the physical examination of patients with angina pectoris will not reveal a great deal of pertinent information. However, the following are clues that may occur during an anginal attack which may be helpful in clarifying the picture of chest pain: (1) *Tachycardia.* In patients with right coronary artery disease, the sinus node may have deficient perfusion and bradycardia with a heart rate of 40 to 60 may be seen. (2) *Elevated systolic blood pressure.* (3) *Presystolic atrial (S_4) gallop.* (4) *Apical systolic murmur.* The murmur of mitral insufficiency may occur during angina. It is produced by subendocardial ischemia resulting in left ventricular papillary muscle dysfunction. A midsystolic click may also be noted as a reflection of papillary muscle dysfunction. (5) *Reversed splitting of the second heart sound.* Approximately one third of patients during anginal episodes may develop abnormal splitting of the second heart sound. (6) *Heart size.* Cardiomegaly is absent unless there is associated hypertension or the patient has had a previous infarction. (7) *Left ventricular (S_3) gallop.* This abnormal sound is absent unless left sided heart failure or mitral regurgitation is present.

Physical Findings in Acute Myocardial Infarction

A. *Palpation.* We find that palpation is best performed with the right hand on the chest and the index and middle finger of the left hand placed on the right carotid artery. In this way, the timing of heart sounds and abnormal myocardial movements is better appreciated. In the majority of patients with myocardial infarction, there is an abnormal apical impulse. This impulse is sustained and is present during mid to late systole. It is present in nearly all patients during the acute episode and may be present long after the insult. It is due to aneurysm or an ischemic area of myocardium that bulges paradoxically during ventricular systole. It is most often palpable midway between the apex and the left sternal border or at the apex of the heart. The position of choice to detect this abnormal impulse is with the patient lying in the left lateral decubitus position. The area of normal apical impulse is the size of a quarter and is felt as a quick rising thrust which ends before midsystole.

Normally, under age 40, an S_4 gallop is not present but may be palpated during myocardial infarction or during angina pectoris. It is felt as an outward movement of the ventricle just prior to systole. It may be brought out by the patient squeezing tightly on the examiner's hand or during situps.

During myocardial infarction the ventricular or S_3 gallop may also be palpable as a small outward movement following systole. Atrial and ventricular gallops are low frequency vibrations which may at times be better palpated than heard with the stethoscope. By the proper timing of the vibrations of the point of maximal impulse (PMI), it may be possible to detect as many as four components. The first is the atrial gallop, second is the systolic impulse, third is the late systolic bulge (associated with myocardial ischemia or infarction), and fourth is the ventricular gallop.

B. *Auscultation.* The heart sounds may be normal or diminished in intensity. (1) *Atrial gallop (S_4).* This abnormal sound is heard in the majority of patients with angina (during the bout of pain) or during an acute myocardial infarction. The atrial component is thought to be due to ischemia resulting in a stiff, noncompliant left ventricle. Recent evidence suggests that an S_4 gallop may be normal in individuals over age 50 without clinical evidence of heart disease. (2) *Ventricular gallop (S_3).* This sound is absent with angina pectoris or myocardial infarction unless accompanied by congestive heart failure or mitral regurgitation from papillary muscle dysfunction (myocardial ischemia or infarction). (3) *Pulsus alternans.* An alternation of strong and weak pulses is one of the first clues of a failing left ventricule. (4) *Pericardial friction rub.* This transient early finding may be discernible in as many as one-fourth

of all patients with an acute myocardial infarction. The rub may have as many as three components or as few as one. It is best to try to elicit at least two components to be sure it is a pericardial rub. It may be missed unless the patient is in the sitting position. If heard several weeks after the acute insult it may be due to the postmyocardial infarction syndrome and not to the infarction per se.

C. *Mitral regurgitation vs ruptured ventricular septum.* The murmurs of these two complications of myocardial infarction are difficult at times to distinguish. However, since differences exist, they can usually be differentiated (Table 1). Ruptured ventricular septum is an infrequent sequel to an acute myocardial infarction occurring several hours to several weeks after the acute insult. The area of involvement is most often the lower septum where the lesion is noted to be single or multiple. A thrill is commonly noted to be present in the 4th and 5th left intercostal spaces at the left sternal margin. The murmur is characteristically holosystolic and harsh and is heard where the thrill is best felt. A right ventricular thrust is present in all cases in which the defect is hemodynamically significant. Mitral regurgitation by contrast is a frequent occurrence of both angina pectoris and acute myocardial infarction, characteristically occurring during the acute attack.

Table 1

DISTINGUISHING FEATURES OF RUPTURED VENTRICULAR SEPTUM VS. MITRAL REGURGITATION

Ruptured Ventricular Septum	Mitral Regurgitation
Infrequent sequel	Frequent occurrence
Several hours to several weeks	During attack of angina or infarction
Single or multiple	Papillary muscle dysfunction or rupture (rarely due to chordae tendineae rupture)
Most common in lower septum	Apical
Murmur holosystolic and harsh	Murmur, holosystolic, high pitched or early, mid or late systole (systolic click may or may not be present)
Thrill present	Thrill unusual
Right ventricular thrust common	Right ventricular thrust unusual
Middiastolic rumble	S^3 filling sound constant

It is due to papillary muscle dysfunction (myocardial ischemia) or rupture (myocardial infarction) and is rarely due to rupture of chordae tendineae. This holosystolic murmur is best heard at the apex. In contrast to the murmur of ventricular septal rupture, it is usually high pitched. The murmur may be localized, but usually radiates into the axillae when the anterior leaflet is involved or radiates to the base of the heart and over the dorsal spine when the posterior leaflet is involved. Thrills are uncommonly seen, but when present, are usually apical in location. Although common with ventricular septal rupture, right ventricular thrusts are most uncommon in mitral regurgitation.

D. *Rupture of the heart into the pericardium.* In a recent Swedish review of 529 cases of acute myocardial infarction, 10% of the deaths were attributed to rupture of the heart. Most of the catastrophes occurred during the first day and were characterized by sudden deterioration, unconsciousness, bradycardia, abrupt decline of arterial pressure, and paradoxical arterial and venous pressures.

E. *Arrhythmias.* Ventricular tachycardia is one of the most frequent arrhythmias seen in acute myocardial infarction. It is usually associated with hypotension or shock. When the atria continue to contract independently of the ventricles there is varying intensity of the first heart sound and cannon A waves are present in the jugular venous pulse. This occurs when the right atrium contracts against a closed tricuspid valve. Carotid sinus massage has no effect on ventricular tachycardia. Atrial fibrillation produces an irregularly irregular rhythm, usually with a ventricular response of 120 to 200 per minute. It may be very difficult to obtain an average heart rate because of the variation of conduction of fibrillatory impulses to the ventricles. Atrial flutter in the acute infarction period is the least seen of the arrhythmias mentioned. It is usually seen as a 2:1 or 4:1 A-V block with a ventricular rate of 150 per minute. Inspection of the jugular venous pulse may reveal flutter waves. Characteristically, the degree of A-V block may be increased by carotid massage with subsequent ventricular slowing.

In Summary

The diagnosis of ischemic heart disease can be established with a high degree of certainty in the majority of cases by a careful history and physical examination. The more common bedside physical signs discussed are due to an ischemic or infarcted left ventricle and the complications which may accompany this problem. The diagnosis of ischemic heart disease or its sequelae in patients with subtle histories can be diagnosed if proper attention is paid to the physical examination.

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Computer Assisted Analysis of Abnormal Laboratory Tests – A Report of Local Experience*

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PART I

PHYSICIAN interest in use of computers to assist in medical practice has been developing slowly for a number of years. The hesitancy to use such adjunctive methods is particularly true in areas away from large research and diagnostic centers and hence, we believe that our experience in Lincoln, Nebraska, in a relatively small 200 bed hospital* may be of interest.

Introduction

We first became interested in the possible use of the computer for assisting in analysis of abnormal laboratory tests in 1970 when we read reports by R. L. Reece[1, 2] and later by Reece and Hobbie.[3]

The initial concept as promulgated by that author was the result of his attaching preprinted diagnostic notes to all abnormal laboratory tests that came out of his laboratory. Accompanying the abnormal laboratory report was a list of possible clinical entities or diagnoses that might account for that abnormity. It seemed rather obvious that the astute clinician and pathologist by virtue of their training and experience could list several diagnostic possibilities that come to mind when there is a single abnormal laboratory test. These preprinted notes, however, included not only the common things that we all readily recall but a more or less complete list including uncommon possibilities gleaned from literature. These preprinted diagnostic notes were well received by referring physicians. As an extension of this concept, the author reasoned that if there was more than one abnormal laboratory test on a given patient and the same diagnosis was suggested by each of the abnormal laboratory tests, this would obviously increase the likelihood of the patient actually having that disease. Furthermore, why not have a computer correlate these preprinted diagnostic lists? If the computer found a diagnosis common to more than one of these lists, the computer

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could be programmed to print a diagnosis or a list of diagnostic possibilities shared by that particular cluster of abnormal laboratory procedures.

The original authors then consulted computer programmers who felt that they would be able to write a program, based on these diagnostic notes, that, in their opinion, would not be too complicated.

We too felt that this offered an interesting concept to assist in the evaluation of abnormal laboratory tests, particularly when one considers that many of the variations obtained in laboratory tests are known to be the result of various medications that the patient has had prescribed, home remedies, food additives, etc. as well as variations due to age, sex, and the ambulatory state. The original authors and subsequently our own group ran several hundred of these computer printouts and then reviewed the charts after the dismissal of the patient. We were pleased to see that in many instances the actual diagnosis as listed by the dismissing physician was at or near the top of the list of diagnoses that had been printed out by the computer on initial admission laboratory testing.

This was the basis for our project here in Lincoln, and although we had been doing this on a limited basis on selected cases for nearly two years, we finally decided that we would obtain this information on a more controlled series of routine admissions to a hospital. We limited our computer analysis to the results of the admission chemistry profile performed on the SMA 12 60. However, we wish to point out that other laboratory tests could be handled in a similar fashion and incorporated in the computer base without too much expansion of the original program. We chose the SMA 12 60 profile of 12 chemistry tests because in our laboratories this was already an automated procedure with a teletype printout and with a paper tape recording of all names and identifying data as well as the results of those laboratory tests.

Purpose of Project

In brief, the primary purpose of our project was to develop a simplified practical method of computer assisted analysis, whereby, there would be placed on the patient's chart a computer printout of the diagnostic possibilities suggested by the abnormalties discovered at the time of the initial admission chemistry profile testing and to have this on the chart within 24 hours of charting the results of admission chemistry profile testing. We were in the process of developing our own computer program for this purpose when Drs. Reece and Hobbie published their procedure including reference to the entire computer program in May, 1972.[3] We thought that we could save time and effort by getting the program directly from those authors at the University of Minnesota but were handicapped by the fact that the computer at the University was considerably different from that at the University of Nebraska* where we were planning to carry out our studies. Similarly, we found that the computer in the hospital selected for the trial run was much too small at that time to be adapted to this type of program.

In preparing the medical staff of the hospital for this project, we were careful to stress the fact that no person or computer could ever completely diagnose clinical conditions by laboratory tests alone, no matter how they were analyzed or how many might be performed, but that there did seem to be a place for this sort of thing. The computer could recall conditions that perhaps the clinician had not already thought of. Also since one can program the computer to label and print results possibly due to drugs and medications of all kinds, and since the computer has an essentially limitless memory, once programmed, it would always suggest those possibilities to explain certain abnormal laboratory tests, if applicable. On the other hand, the pathologist or clinician may not always remember the various drugs and diseases that could affect certain laboratory tests.

Although our purpose was simple, and the procedure quite well worked out in advance by others,[1, 2, 4, 5] there were many problems in getting the program going on an efficient routine basis. Most of these problems con-

*IBM 360/65 computer, located at University of Nebraska, Lincoln, Nebraska.

cerned logistics of getting the printed results from the SMA 12/60 onto punch cards and into the computer on a daily basis. The actual computer analysis, after the program had been established and punch cards made, is indescribably fast. We were unsuccessful in trying to adapt the paper tape which accompanied the SMA results directly to punch cards.

Project Details and Costs

Although there was a substantial initial cost to the project, once the program was under way we felt that its cost could be held to 25 cents or less per printout (per chemistry profile analyzed). Also, another problem that needed to be solved was to get the computer printout onto paper the same size as our regular profile report form. This was soon accomplished, and we proceeded with the project. For a period of one month (June, 1973) we furnished, without extra charge to the patient, a computer printout of possible diagnoses suggested by the routine SMA chemistry profile on regular admissions to the hospital. All admissions to the hospital were included with the exception of routine admissions in the pediatrics and obstetrical departments. A total of 757 admissions with routine chemistry profile studies were recorded and analyzed by the computer during that period of time.

We also had to make further adjustments as the program proceeded; e.g. to specify that certain tests were tagged as critical or essential to a given diagnosis, by the computer. For example, diabetes would not be listed as a possible diagnostic consideration unless there was an elevated blood glucose. Significant renal disease was not listed as a possibility, unless there was elevation of the blood urea nitrogen. Adjustments also were made and the normals adjusted for age and sex and local chemical methodology. Also as much as possible, we eliminated certain diagnoses. For example, we eliminated the diagnosis of pregnancy in the male and similar incongruities that become a source of some good natured humor, at our expense, by the medical staff.

Although the major purpose of the project was as indicated above, to put a computer printout on the chart along with or shortly after the results of chemistry profile test results, there were some by-products of this major purpose. It was built into the program to have the computer record the degree of deviation from normal in terms of the number of standard deviations from a given normal range. Thus, not only the normal values were recorded and printed but the number of standard deviations from the normal was also given.

Also we furnished many of our referring physicians a portion of Reece and Hobbie's article[3] listing about 78 abnormal conditions or diseases for which specific combinations of abnormal laboratory findings would be expected. This increased the ability of all to evaluate results of SMA 12/60 profiles, *without a computer*. Another byproduct was the fact that the project served as a practical introduction to applied computer science for medical students, interns, residents, our own group of pathologists and the medical staff, and in this way we believe served as a stimulus for greater interest in the use of computers in medicine.

Cancer Genetics: Urological System Part I*

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Renal Carcinoma (Hypernephroma)

CARCINOMA of the kidney has been infrequently reported in families. Brinton[1] reported three cases of "hypernephroma" occurring in siblings based on autopsy or biopsy reports. The father was also allegedly treated for a kidney tumor and the mother died of "cancer," though a pathology report was not available. Riches[2] studied a series of 130 cases of renal cancer and found only one familial occurrence, in this case in siblings. Specifically, a brother had a renal tumor composed of a mixture of clear and granular cells while his sister had a renal tumor consisting entirely of clear cells. Rusche[3] reported two brothers with renal carcinoma who presented clinically with metastases. Klinger[4] reported a brother and sister with renal cell carcinomas.

Steinberg and associates[5] reported the occurrence of carcinoma of the kidney in a mother and her daughter. Consanquinity was absent in this family. Karyotypes from peripheral blood were normal in both patients. No unusual environmental exposures were found which could be responsible for renal neoplasms. Cancer was not present in any other members of this family.

A remarkable family was reported by Franksson and associates[6] in which all five siblings in the sibship developed renal carcinoma (hypernephroma). In four of these siblings renal carcinoma was bilateral. Symptoms appeared in the patients between the ages of 37 and 53; they were typical of renal carcinoma. Interestingly, one of the siblings had polycystic kidneys in addition to renal carcinomas, while another sibling had fibrosarcoma in the region of the scapula. Another sibling with renal carcinoma had optic atrophy, and finally another sibling had mental retardation. The father of these patients died of a cerebral vascular accident. However, an autopsy was not performed. Their mother had schizophrenia. It was of interest that the hypernephromas in each of these siblings were remarkably similar. Specifically, the tumors consisted of tubular or papillary structures with poorly developed connective tissue matrix. The epithelial cells were regularly cylindrical, with granular cytoplasm and small monomorphic chromatin-rich nuclei. The frequency of mitosis was low. No invasion was apparent in the growth of the large veins in the hilum. In limited areas of some tumors, cells of a clear cell type were seen in apparently tubular or completely irregular grouping in a fine fibrillary matrix.[6]

The authors were impressed with the possibility that the findings in this family were consistent with autosomal dominantly inherited von Hippel - Lindau's disease[7-10] wherein bilateral multiple renal carcinoma has been described previously.[7, 10] In addition, renal carcinoma has been described previously in polycystic kidneys.[11] Hamartomas of the kidneys have been found in patients with autosomal dominantly inherited tuberous sclerosis.[12-15]

While a familial variety of hyperhephroma is likely, the overwhelming majority of cases of renal carcinoma apparently are not familial and must therefore result from differing etiologies. However, the occasional reports of carcinoma of the kidney in siblings or in more than one generation of the family suggest the possibility of hereditary etiologic factors in certain circumstances; however, these infrequent occurrences are insufficient to delineate the precise genetic mechanism(s). On the other hand, the occurence of renal carcinoma in a known hereditary disorder, i.e., von Hippel-Lindau's disease, is intriguing since this autosomal dominantly inherited disorder harbors a propen-

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sity for the production of cerebellar hemangioblastoma and apparently also predisposes through unknown mechanism to the production of renal carcinoma (discussed subsequently).

Polycystic Kidneys Associated With Renal Carcinoma

It has been estimated that the incidence of polycystic kidneys is approximately one in 350 live births (Figure 1). No predilection for sex has been demonstrated in this disease, which tends to peak at two ages: one in *infancy*, which is usually due to autosomal recessive inheritance, and the second, in *adulthood*, due to autosomal dominant inheritance. While bilateral polycystic kidney disease occurs more frequently, the incidence of unilateral polycystic kidney disease has been reported as being between four and 13 percent. The infantile type is usually more severe with cystic disease involving

Figure 1 — Patient with polycystic kidney disease (a) who, in addition, showed cystic lesions in the liver (b). (Courtesy of A. C. Allen, M.D.)

most of the functioning kidney with generally poor survival. On the other hand, more functioning kidney tissue is present in the adult variety which permits significantly longer survival. In addition, there appears to be a marked variation in progression of cystic enlargement in the adult form with lesser degree of destruction of the kidney. In some kindreds with the adult variety, certain affected relatives may have normal longevity; indeed, they may have been considered normal, only to find incontrovertible evidence of the disease at necropsy. This is of extreme importance in pedigree analysis as well as in genetic counseling, since one might seriously err by concluding that a "generation was skipped" when in fact the patient under consideration was actually *affected* and hence, harbored the deleterious dominant gene with the propensity to transmit it to approximately 50 percent of his progeny.[16]

The adult variety may show an increased association with intra-cranial aneurysms in some families. These include berry aneurysms near the bifurcation of cerebral arteries which occur to about 17 percent of patients; on the other hand, approximately four percent of all patients with intracranial aneurysms have polycystic kidneys. Polycystic kidneys may also occur in von Hippel-Lindau's disease which is also inherited as an autosomal dominant.

Renal carcinoma has been described in association with polycystic kidneys, though the frequency of this association is not accurately known. However, review of the literature suggest that it may be more common than usually credited.[17] Thus, Howard and Young in 1968[18] referred to 17 cases from the literature and added one of their own. Siegelman and associates[19] reported a patient who had renal carcinoma and polycystic kidney disease in association with neurofribromatosis. Bilateral renal carcinoma in assoation with polycystic kidneys was reported by Borski and Kimbrough.[20] The report by Roberts[17] also involved bilateral renal carcinoma in association with polycystic kidneys. This particular case was unique in that there appeared to be simultaneous tumor formation in both kidneys. Each tumor represented a different histologic variety of renal carcinoma which supported the view that the neoplastic change was multicentric in origin as opposed to metastases from a primary focus.

It is important to consider renal carcinoma as a complication of polycystic kidney disease in that polycystic kidney disease is now being treated successfully by renal dialysis as well as by renal transplantation. With respect to transplantation, should the risk for carcinoma appear to be significant, this could have a bearing on the timing for prophylactic nephrectomy. Further studies of renal carcinoma in association with polycystic kidney disease should take into consideration the family history for carcinoma of all varieties including that of the kidney. Thus, we may find that certain families with dominantly inherited polycystic disease may have a greater risk for the development of cancer by virtue of a preexisting familial proclivity for cancer. We must also consider environmental factors. For example, patients suspected of polycystic kidney disease may undergo repeated diagnostic x-rays including intravenous pyelograms. Excessive radiation exposure could conceivably trigger malignant transformation in individuals bearing susceptibility to cancer.

von Hippel-Lindau's Disease and Renal Tumors

von Hippel - Lindau's disease typically shows a constellation of angiomatosis of the retina and cerebellum and tumors of various organs (hemangiomas and multiple cystadenomas, including cavernous hemangiomas of the face and neck). Cysts may occur in the liver or pancreas and kidney (Figure 2). In the latter organ, angiomas, adenomas, and carcinomas have been described.[21]

von Hippel-Lindau's disease is inherited as an autosomal dominant with variable expressivity of the gene.[16]

Tuberous Sclerosis

The typical clinical findings in tuberous sclerosis include adenoma sebacea (actually this is a hamartoma, in which the sebaceous glands are only passively involved) of the face, epilepsy, and mental retardation. This condition is inherited as an autosomal dominant with a wide range of expressivity of

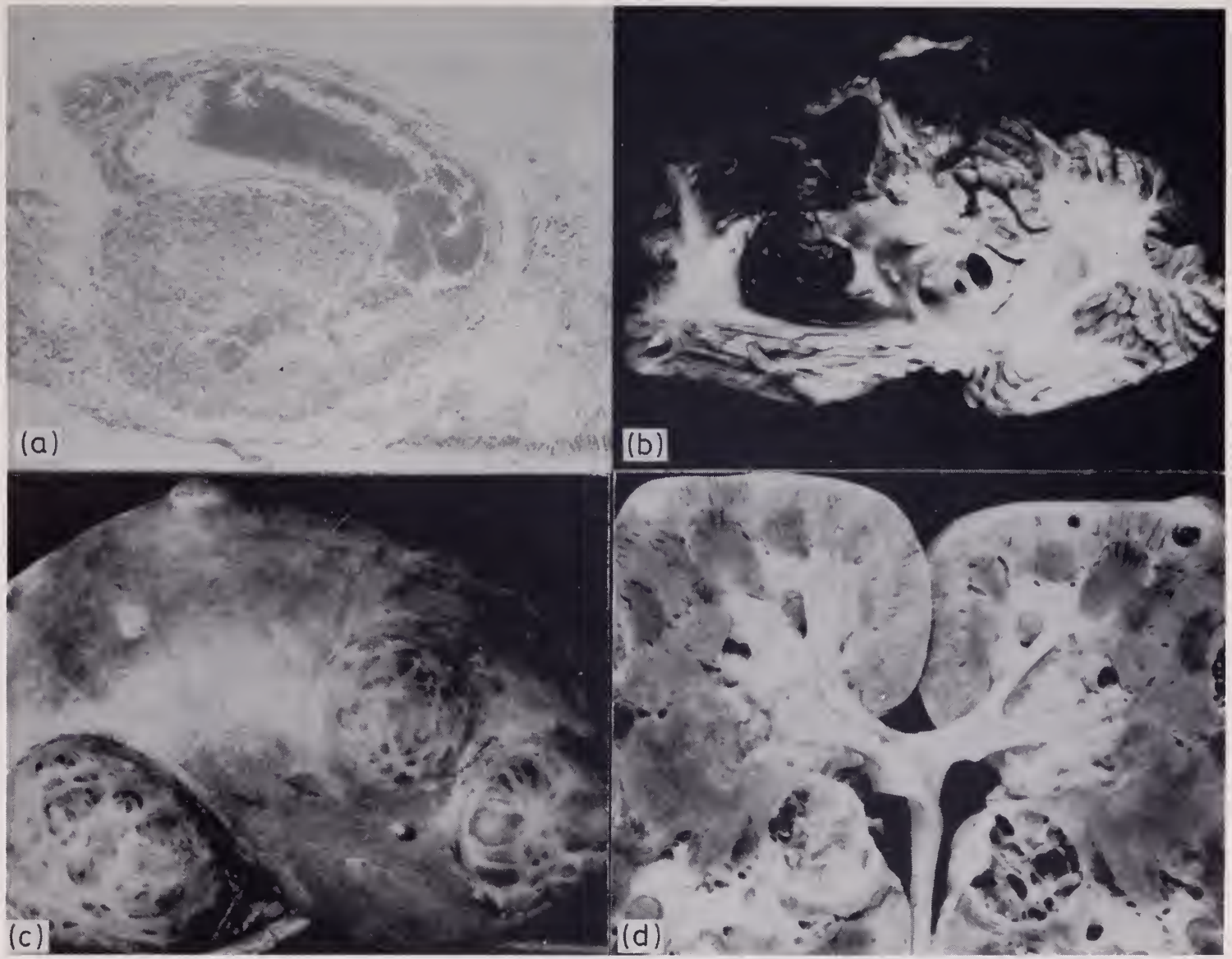

Figure 2. — Post-mortem findings from a patient with von Hippel-Lindau's disease. (a) shows retinal angiomatosis; (b) illustrates haemangioblastoma of the cerebellum; (c) and (d) show polycystic disease of the kidney. (Courtesy of Haruo Okazaki, M.D.).

Figure 3 — Three patients with tuberous sclerosis showing variable expressivity as evidenced by phenotypic variation in expression of adenoma sebaceum (A, B, C). Photo in D shows intra-cranial findings of cortical tubera.

the gene. Tumor-like masses, or "hamartomas" are found in several major organs, including the brain, heart, and the kidneys (Figure 3). The renal tumors are usually multiple, are small in size, and may consist of adenomas, leiomyomas, angiomas, lipomas and fibromas, or complex mixtures comprising elements of these specific growths. Sarcomatous changes may occur on rare occasions in these renal lesions.[22-24]

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What Is MECO?

BRUCE C. PINKERTON

CURRENTLY, more and more medical schools are involved in programs to educate the kind of doctors the public wants. And the public wants family practitioners. As you know, most graduates of U.S. medical schools stay in the city or affiliate with a university. We need more "first-liners," doctors to utilize their special skills in the small communities of the country. We really need more physicians in the role of primary health care — that is, family practice, pediatrics, internal medicine, and so forth.

To this end, the Student American Medical Association (SAMA) began a program known as MECO (Medical Education and Community Orientation). The pilot project took place in Illinois in the summer of 1969 and was declared an instant success. Twenty-six medical students, who hadn't had any clinical experience, were distributed to 26 Illinois hospitals. They lived in the communities and worked beside physicians to gain a better understanding of medicine the way it really is.

What is MECO? It's an exciting program with two long-range goals. First, "to effect a redistribution of health manpower in the U.S." Through exposure of the student to the community health care delivery before he is forced into a career choice concerning location and specialization, MECO provides the student with the required information he needs to consider community practice as a career. "More than 2/3 of student participants over the past three years have stated they would be interested in returning to their MECO community or some similar community to practice." Therefore, MECO appears to be meeting the first of its long-range goals.

Second, MECO is concerned with fostering a method by which the practicing physician's education may be perpetuated. It was felt that current methods do not adequately prepare the student for continuing his education once he is out of the academic community. MECO allows the student to actively participate in setting up his own program and thus gives him the opportunity to establish educational patterns which can only help him improve his knowledge in the future. Ron Schwab, a Nebraska 1973 MECO participant said, "During the course of my MECO project, I was continually being prepared, either directly or indirectly, for my upcoming National Boards, Part I"

One could also conceive of a third long-range effect MECO will have upon its participants. That is, future patterns of health care delivery will be affected. Since the student is exposed to community medicine and all the forces that mold it, it is reasonable to assume that he will be more sensitive to the need for health care programs which integrate smoothly with community life and satisfy community needs.

MECO began in Nebraska in 1971 with a pilot program in Osmond, Nebraska. Everyone involved was enthusiastic about it, and the project was a big success. Then, in 1972, with the help of the Nebraska Medical Association, the Nebraska Hospital Association, and the Nebraska Regional Medical Program, 22 students were placed in 13 hospitals and clinics in the state of Nebraska for eight weeks of their summer vacation. The 1973 project involved twenty Creighton University and UNMC students in 15 hospitals and clinics.

For Nebraska and Creighton University students, MECO provided a mechanism through which they could become intimately acquainted with his or her assigned community. Most lived in the community hospital with which they were associated. They went on call with the physicians, scrubbed in, read charts, started IVs, took histories and physicals, learned the jargon, talked to patients, and finally got their hands dirty after a year or two of strictly

didactic, book medicine; all were extremely grateful for the opportunity.

Financial remuneration was supplied each student, and most were given free room and board. Sears-Roebuck Foundation provided the original funding for the national development of MECO. After the successful completion of the 1969 project in Illinois, Sears awarded a three-year administrative grant to SAMA for national expansion. Thus far, projects have been intiated in 40 states and the initial plans formulated in 15 more. The tremendous success of MECO is, however, more rightly attributable to the gratifying local support in the form of enthusiasm and funding. Participating physicians, community groups, state hospital associations, state medical societies, etc., have provided manpower and time for local project development and recruitment of hospitals and clinics.

MECO has been especially good for students in the three-year program at UNMC, since their elective time has been undermined compared to previous classes. MECO allows some students to spend their five-week summer vacation, gaining invaluable preclinical experience. Recently, at Nebraska's Medical College, MECO has been granted the status of a regular accredited course. The agreement was worked out with the Curriculum Committee with the stipulation that the project would remain student-run and student-initiated. This is an unique and innovative approach, as I know of no other institution where an opportunity of this type is offered by students while at the same time receiving college credit.

As you can see, Nebraska SAMA members have worked hard to get MECO started in Nebraska, but more help is needed from outlying Nebraska communities. Every year more students apply for projects than are available. If you are interested in starting a project in your community, you should contact Gretchen McCoy, 1975 Nebraska MECO Project Chairman at the UNMC, for more information.

What of the future of MECO and SAMA in Nebraska and elsewhere? Accent is now being placed on a project similar to MECO, but having an interdisciplinary approach. That is, no less than three students would participate in a project, and the emphasis would be placed on the team approach to health care delivery. Again, educational goals are foremost with service consideration being secondarily included to enhance the educational experience. A pilot project was conducted in June through August 1972 through Indiana University/Purdue University using the interdisciplinary concept.

In Nebraska, the interdisciplinary approach was introduced in Kearney and Curtis during July and August of 1973. The Curtis group was composed of students in medicine, nursing, social work, and dental hygiene, while the Kearney team consisted of a medical student, nursing and pharmacy student. Originally it was planned that all students be from Nebraska, but due to late funding confirmation, other students from across the nation had to be recruited.

The students lived and worked in their respective communities. Goals and specific activities were defined by each group with the concept of a team approach always foremost in their minds. Morning activities revolved around individual projects such as spending time in homes for the elderly, county welfare office, dentist office, veterinary clinic, and an attorney's office. Afternoons were spent utilizing the team to formulate consumer education programs in venereal disease, alcohol and drug abuse, first aid, nutrition, diseases of middle age, communicable disease, a Children's Health Fair, and newspaper articles.

As you can see, concerned Nebraska University and Creighton University students are striving to change the health care delivery picture in Nebraska and the United States. It's a big project, but then anything worthwhile always seems to be. However, we are all quite enthusiastic about these projects with the backing of our fine universities and the cooperation of the many fine people in rural communities.

The Role of Exploratory Laparotomy For Chronic Abdominal Pain in Children

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IN the last 25 years, numerous papers have been written about chronic abdominal pain in children. The majority of these children have a psychological etiology for their pain.[1-5] Those with organic etiologies can usually be diagnosed by nonoperative methods.[1, 6-12] A few of patients with no proven organic or psychologic cause of their pain have been explored. Generally, this has been done because of the severity and chronicity of the pain which, in some cases, has been amplified by relentless pressure placed upon the physician by concerned parents. It would be of considerable value to the physician to know what conditions might be anticipated before considering a recommendation of exploratory celiotomy in these children.

A review of the literature shows no description of the operative findings in such cases. Therefore, we have reviewed the hospital and outpatient records of 15 cases of chronic, recurrent abdominal pain in 11 years at Children's Memorial Hospital in Omaha, Nebraska. All but one were operated upon by one of the authors (LRS).

Patients and Methods

Records reviewed in this retrospective study were obtained from the medical records cataloging system. All retrievable records of patients explored for chronic, recurrent abdominal pain were included in this study. The decision to explore was based on the presence of all of the following criteria:

1. severe recurrent abdominal pain lasting longer than three months and frequently awakening the child at night;
2. no evidence of psychological problems as evaluated by the pediatrician;
3. normal physical exam with the exception of vague abdominal tenderness;
4. normal or doubtfully significant findings on upper and lower gastrointestinal x-ray studies, intravenous pyelogram, complete blood count, and urinalysis;
5. pain sufficiently severe to cause disruption in daily living patterns and resulting in multiple hospitalizations;
6. pain unresponsive to medical and supportive management.

Our 15 patients included 12 girls (80%) and 3 boys (20%) with 2.2 admissions per patient, the most being five. Two were Negro and the remainder Caucasian. Preoperative evaluation by their pediatrician included a thorough history and physical examination with exploration into possible psychological or psychiatric problems. Average age at onset of pain was 9.6 years, with operation performed at 10.1 years. One patient was explored twice. Pain was usually described as a dull ache with occasional sharp stabbing pains. The right lower quadrant was involved most frequently, with the periumbilical region next. The pain awakened 80% of these children from sleep, and had caused most to miss many days of school. Vague abdominal tenderness was the only positive physical finding other than 3 children with small umbilical hernias.

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All patients had intravenous pyelography, upper and lower gastrointestinal barium studies, complete blood counts, and urinalysis, with some patients having more intensive evaluation as indicated by history. Roentgenologic examination in one patient showed a redundant cecum and another had possible diffuse enteritis; the rest were normal. Four oral cholecystograms were normal. In each case, it was determined preoperatively that no diagnosable medical etiology for the pain could be found.

Operative Findings

Our operative exploration included thorough examination of the abdominal cavity, correction of any pathologic findings, and removing the appendix if present. Four cases of focal appendicitis as described by Schenken et al[13] were found (Table 1). This pathologic entity connotes purulent exudate in the lumen of a vermiform appendix, the source of which is a small mucosal ulcer. These changes may progress to acute suppurative appendicitis.[13] It is, however, only presumptive to assume that correlation exists between a continuing low grade focal appendicitis and the recurrent pain in any of these cases.

Adhesions were found in four cases. One child had undergone a previous operation, and the adhesions were felt to be secondary to that procedure. In 3 cases the adhesions were congenital, two with the terminal ileum and cecum fixed tightly to the region of the right ovary, and one with small bowel adhesions. None of these appeared to be causing obstruction at time of operation. Neither duodenal band was obstructing.

Three cases of Meckel's diverticulum which were not diagnosed preoperatively were found and removed. Pathological examination showed none of the diverticuli contained gastric mucosa, nor were they inflamed, bleeding, or ulcerated at the time of exploration.

Table 1

OPERATIVE FINDINGS ASSOCIATED WITH ABDOMINAL PAIN

Focal appendicitis	4
Adhesions	4
Meckle's diverticulum	3
Duodenal band	2
Irritable bowel syndrome	2
Mesenteric lymphadenitis	1

Irritable bowel syndrome as described by Stone and Barbero[4] was diagnosed in two children. The colons in each of these children were dilated with pellet-like stool present throughout the descending colon. Both improved postoperatively on stool softeners.

Nonspecific mesenteric lymphadenitis was found and biopsied in one child. Because this entity occurs with acute upper respiratory tracy infections, recurrent pain might have resulted from a chronic lymphadenitis in the mesentery. However, no association between the abdominal pain and concommitant chronic upper respiratory infections was noted in this study.

Two of the girls were found to have small congenital hydatid ovarian cysts which we did not feel contributed to the pain of these children. Other incidental operative findings included inquinal canal weakness, mobile cecum, transient operative intussusception, and the preoperatively diagnosed umbilical hernias.

The postoperative course was satisfactory in each of these cases with no major complications or deaths. Nine of the 12 patients (75%) available for followup extending over a period of one to nine years have been asymptomatic after laparotomy (Table 2). Three of these 9 patients had normal findings at laparotomy. Those 3 patients with persistant postoperative symptoms all had positive findings at exploration (adhesions, duodenal band, and mesenteric lymphadenitis). Two of these have had significantly less pain resulting in minimal modification of daily activities since their surgical explorations.

Discussion

Chronic recurrent abdominal pain is a common problem in the daily office and hospital practice of pediatrics. Apley[1] has shown that approximately 10% of school age children have this affliction. His studies also found that only one in 15 had an organic cause for his pain. Wood et al[12] described

an organic etiology in 20% of his series of 95 patients. These studies, however, include cases with preoperatively diagnosable organic lesions. Although our series is not large enough for adequate statistical analysis, the percentage of organic lesions present in our cases is certainly much higher than in these other reported series. One might attribute this discrepancy to one of three possibilities: (1) patients were selected for exploration largely because of the severity of their symptoms, (2) the organic lesions found might not actually be the cause of the abdominal pain, and (3) the series is small enough that this could be only statistical coincidence.

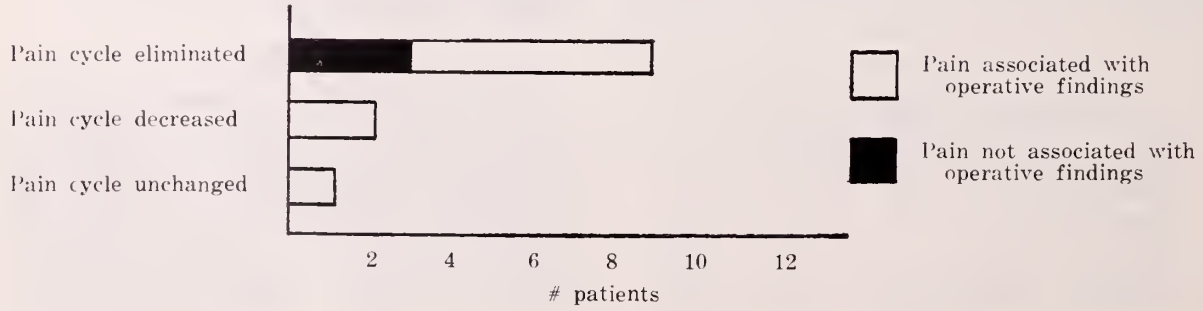
Our operative findings included congenital intestinal adhesions, focal appendicitis, Meckel's diverticulum, irritable bowel syndrome, duodenal bands, and mesenteric lymphadenitis (Table 1). There are other organic causes of recurrent abdominal pain which were not found or were preoperatively excluded in our series of patients. Urinary tract disorders account for the largest portion of these. Apley[6] reported approximately 50 percent of his patients with an organic cause for chronic abdominal pain had urinary tract disorders. Most were diagnosed without surgical manipulation. Other causes found by exploration would include multiple intestinal polyps,[14] recurrent volvulus,[12] duplication of the ileum,[8] incarcerated internal hernia,[12] and foreign bodies.[4] Neonatal problems which might cause chronic abdominal pain include prolonged colic, diarrhea, and vomiting. Stone and Barbero[5] noted these neonatal problems in 31% of the children they studied, however, these problems were not a prominent part of the history of our patients.

Most commonly, chronic recurrent abdominal pain in childhood has no organic etiology but is associated with a strong emotional component. These emotional difficulties may produce severe pain, chronicity, and disturbances in life style which require frequent hospitalizations. It is essential to rule out organic causes of pain before labeling a child as having an emotional problem. This usually can be done without celiotomy. Emotional causes are suggested by the physician's personal observation of the patient and his interaction with his family. This should include detailed discussion with the child and his parents about circumstances surrounding the pain cycle, especially the original episode. If the diagnosis of a psychological cause is made, the patient and his family should be given a thorough explanation of the problem and attempts should be made to break the pain cycle by altering the personal or family situation which precipitated the problem.

Summary

One must be cautious in drawing conclusions from this study. It is interesting that such a high percentage of cases had abnormalities on exploratory celiotomy. All but one patient were explored by one of the authors (LRS), so preoperative and intraoperative evaluation was uniform. The decision to operate was based uniformily upon the severity of the symptoms, rather than any other easily definable criteria. The percentage of patients obtaining relief from their pain is quite high. In addition to the

Table 2
FOLLOW-UP ON TWELVE PATIENTS



presence of correctable lesions, one must consider the possibility that the operative procedure may have altered family relationships in such a way as to modify the psychological cause. In addition, the placebo effect of a surgical procedure must be considered as Howie[15] has noted that removal of a normal appendix was associated with relief of symptoms in 86% of his patients with right lower quadrant pain.

Finally, it does appear that the role of exploratory celiotomy in chronic recurrent abdominal pain needs further evaluation through a well designed prospective study. It is doubtful that laparoscopy would be helpful in such a study since many of these findings, such as focal appendicitis, would not have been observed with this procedure. Operative intervention in these patients with chronic recurrent abdominal pain must remain as the final diagnostic procedure for the most severe cases. However, we believe more investigation of its uses in this select group of patients is warranted.

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The Changing Emphasis in Gross Anatomy

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THE University of Nebraska College of Medicine is one of many medical schools which have experienced a progressive decrease in the number of hours allotted to the basic medical sciences.[1, 2] In medical gross anatomy, for example, the Educational Affairs Committee of the American Association of Anatomists[3] reported in 1966 a mean of 290 hours. In 1973, a national survey[4] indicated that most medical schools offered courses of between 140 and 280 hours with a national average of 197 hours. At Nebraska, the time allotment for gross anatomy during 1973 was 156 hours.

A Clinical Approach

The reduced time allotment for gross anatomy necessitates a structuring of the gross anatomy curriculum away from anatomical detail toward functional and clinical applications. Although a clinical approach to teaching gross anatomy has always been a characteristic of the Nebraska curriculum, several new features, which are based on an instructional system originally developed at the University of Iowa, have recently been added. These may collectively be termed the "physician motivation approach."[5] In order to use the physician motivation approach, instructional objectives were carefully developed on the basis of the cognitive abilities and the psychomotor skills the student is likely to need as a future physician.[6, 7] The instructional objectives then served as a foundation for the development of a student centered gross anatomy course[8] which employs such modern instructional methods as programmed learning[9, 10] auto - instructional packaging,[11, 12] clinical pathology reports on cadaver specimens[13, 14] weekly clinical problems, and more traditional teaching methods such as clinical lectures by practicing physicians and clinical motivational movies. Perhaps the most important aspect of the Nebraska program, however, is the weekly sessions of "Living Anatomy"[15] which are used to teach some of the basic skills of physical diagnosis and allows students to demonstrate or to see on eath other, live, the structures they have dissected on the cadaver.

Results

Although the affective area is difficult to evaluate, examination of Table 1 indicates that the clinical approach is successful in convincing the students of the importance of gross anatomy for the practice of medicine. In addition, it can be seen that the clinical anatomy lectures and the living anatomy

Table 1

STUDENT ATTITUDE TOWARD THE PHYSICIAN MOTIVATION APPROACH

Questionnaire Item	5 %	4 %	3 %	2 %	1 %
1. Value of gross anatomy for the practice of medicine	66	27	6	1	0
2. Clinical anatomy lectures	47	37	14	2	0
3. Motivational clinical movies	15	69	12	4	0
4. Clinical pathology reports	30	24	34	7	5
5. Living anatomy	44	47	7	2	0

SCALE:
5 = Highly valuable
4 = Valuable
3 = Of some value
2 = Of little value
1 = Useless

The results of a questionnaire submitted to a random sample of freshman medical students (N = 80, 97% return).

program were felt to be particularly valuable. The clinical movies and pathology reports were also well accepted.

Discussion

The basic medical sciences are often taught by nonmedical Ph.D.s. The fear is sometimes expressed that a clinical approach to the basic sciences will not be accepted by the clinical departments. On the contrary, the clinical approach to gross anatomy at the University of Nebraska College of Medicine is both accepted and encouraged by clinicians and students alike. The success of this approach prompted the Internal Medicine Department to transfer to gross anatomy 36 hours of its allocated time in order to facilitate the teaching of gross anatomy, and especially "Living Anatomy." Furthermore, the clinical departments have offered to supply medical interns and residents to participate in a joint instructional capacity with anatomy faculty in this program. It is hoped that this will further serve to increase the effectiveness of the clinical approach and its usefulness as a motivational device.

Conclusion

It is concluded that the use of the powerful motivational force of the clinical approach in teaching gross anatomy can be successfully utilized by a nonclinical basic science department.

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Gaucher's Disease: Case Report

R. D. SCOTT, M.D.;
D. L. BACON, M.D.;
W. H. NORTHWALL
Assistant Professor of Radiology,
University of Nebraska
and
G. L. MORRIS
Assistant Professor Pathology

GAUCHER'S disease is one of the sphingolipidystrophies and represents a specific enzymatic deficiency. The disease is one of the first of this category to be identified and was originally described in 1882 by Phillipe C. E. Gaucher. The deficiency is a deficit of the enzyme glucocerebrosidase which mediates the break down of glucocrebroside to glucose and ceramide.[1] The following represents a case report.

Mr. C. R. is a 37 year old gentleman who has been in good health throughout most of his life. His occupation has been that of a farmer or fertilizer salesman, having grown up on the farm. As a youngster, there was some disease in their herd, which he states was either brucellosis or leptospirosis. He relates that he has always been an easy bruiser and bleeder, having fairly frequent nosebleeds and a history of losing three pints of blood following a tonsillectomy. His presenting complaint was a bruise which appeared on the anterior tibial surface of the left leg. Preliminary evaluation at that time revealed a platelet count of 60,000 with minimal prolongation of the prothrombin time and partial thromboplastin time. He was found at this time to have an enlarged liver and spleen and was admitted to the hospital for evaluation.

Past Medical History: Two years prior to being seen, the patient had a similar episode with low platelet counts, easy bruising and bleeding. A bone marrow was attempted at that time which did not yield an adequate specimen but the material obtained was interpreted as being within normal limits. The patient's platelet count gradually increased without treatment, and it was the impression at that time that perhaps his exposure to pesticides had affected the platelet count.

Family History: Both parents are living. The mother has a history of hypertension. There are two brothers and a sister. One brother has been diagnosed as having Gaucher's disease. The other brother refuses examination. The sister is free of the disease.

Physical Examination: The positive findings were confined to the abdominal exam which revealed hepatosplenomegaly with the liver being down from the right costal margin 4 cm. in the midclavicular line. There was splenomegaly with the spleen being down from the left costal margin 6 cm. No other masses were noted in the abdomen.

Laboratory Data: The blood count, red cell indices, sed. rate, prothrombin time, partial thromboplastin time, urinalysis serum calcium, alkaline phosphatase, rheumatoid factor, electrolytes, fasting blood sugar, BUN, uric acid, bilirubin, SGOT, total serum protein and protein electrophoresis, serology, febrile agglutinins, serology for leptospirosis, BSP, and fibrinogen were either negative or within normal limits. The platelet count was 58,000, reticulocyte count 2.9%, clot retraction showed 3+ fallout and a serum acid phosphatase was 5.4 international units.

Radiologic Studies: Two changes were noted on x-ray examination, namely splenomegaly and an abnormal appearance to both femoral shafts. No skeletal involvement was found elsewhere.

The changes in the femora consists of obliteration of the intramedullary trabeculae from the trochanteric region to the distal femoral shaft, associated with endosteal cortical thinning in the same region and in some areas there is periosteal new bone formation resulting in widening of the

external femoral diameter. There is gradual widening in this region between the condylar portion of the femur and the femoral shaft. The latter change has been likened to the appearance of an Erlenmeyer flask.

The bilateral symmetry of bony involvement suggests a systemic disorder. The poor remodeling of the distal femora suggests that the disorder has been present over a long period of time. The expansion of the intramedullary canal with loss of trabeculae suggests that there is bone marrow replacement occurring. The bony change, in conjunction with splenomegaly, suggests that a storage disease of the reticuloendothelial system is present.

Pathology: Several attempts at bone marrow aspiration were tried from the left posterior illiac crest and were unsuccessful, so a needle bone biopsy was done. An imprint shows a hypercellular marrow with normal granulocytic and erthrocytic elements. In addition, numerous large cells

were seen which contain eccentric nuclei and bluish-white cytoplasm.

The cytoplasm has a reticular pattern that resembles wrinkled tissue paper or crumpled silk. These cells are representative of the pathognomonic cell of Gaucher.

Additional tissue, including an iliac crest biopsy, liver biopsy and spleen from the patient's brother, were reviewed and they also showed the characteristic cells.

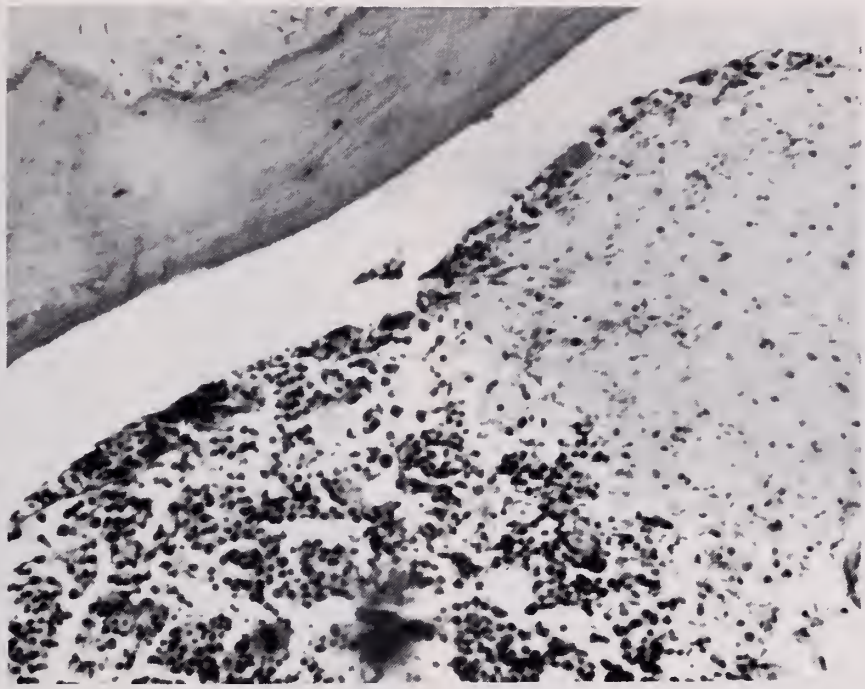
Clinical Features: Gaucher's disease occurs with equal frequency in men and women. The incidence of this disease has been best demonstrated for families who have an Ashkenazic Jewish background.[2] It has been reported, however, in most of the other races of the world, including orientals, caucasians, and negroes.

Two types of the disease exist: a juvenile form and an adult form. The most common form of the disease is the adult form. Many patients in this category have moderate anemia, thrombocytopenia, and a brownish-yellow pigmentation of the skin, along

with the hepato-splenomegaly. In some cases, the presenting difficulty is a pathologic fracture of the femur or pelvis. Gaucher's disease is usually transmitted as an autosomal recessive with a frequency in known populations of from 1 in 10,000 to 1 in 30,000.[3]

Diagnosis is usually established by the finding of a normocytic anemia with the lipid laiden Gaucher cells in the bone marrow. Frequently there is an elevation of the serum acid phosphatase which is not inhibited by sodium tartrate. A specific test is the demonstration of a deficiency of Beta-glucosidase in peripheral leukocytes.[4]

A mild factor IX deficiency has been described with Gaucher's disease.[5] Sporatic deficiencies of other coagulation factors,



factors V, VIII and IX have been found in other patients.[5] The reason for the factor IX deficiency has been described as possible binding factor X, or other plasma coagulation factors, by an abnormal lipid or phospholipid.

Treatment: When the patient presents with adult splenomegaly and thrombocytopenia, it has been proposed that splenectomy be carried out as the patient is subject to splenic fractures and increasing thrombocytopenia. It has been observed, however, that patients who have splenectomies seem to have an accelerated bone and hepatic involvement.[6] It has been hypothesized that the absence of the spleen results in hyperplasia of the remainder of the reticuloendothelial system and that excess glucocerebroside continues to accumulate in the remaining RE cells.

If the thrombocytopenia reoccurs after splenectomy, one must consider the possibility of an accessory spleen having hypertrophied after the primary spleen has been removed, and the patient should be considered for exploration with the thought in mind of finding an accessory spleen.[7]

Complications of the process include silent aseptic necrosis of the bone, osteochondritis type of symptoms which are similar to Perthes' disease of the hip, and slow destruction of the bone followed by collapse and degenerative arthritis. Management of bone lesions depend upon the presenting symptoms. Incision into the area of the bone lesion often leads to infection and the development of a secondary pyogenic osteomyelitis. In the late stages, the role of the surgeon is to prevent deformities by splinting and treating pathologic fractures by internal fixation. Progress of the bone disease is uninfluenced by a form of treatment and follows the natural history of the disease.[8] Other complications include elevated hepatic portal pressures and portal hypertension.

Clinical followup: After observation for approximately ten months, it was noted that the spleen was gradually increasing in size from the original 6 cm enlargement to 9 cm enlargement. His platelets in the interim had never risen above 80,000. An elective spleenectomy was carried out without significant complications. Three accessory spleens were also removed at that time. His platelet count six hours after surgery was 225,000. He has done well post operatively and now is being followed each four months.

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Special recognition should be made to P. S. S. Murthy, M.D.; Lloyd Wagner, M.D., and Fred Rutt, M.D., who aided us in the recovery of information regarding our patient's brother.

Radiology Case of the Month

ROBERT W. WALKER, M.D.
Department of Radiology,
University of Nebraska School of Medicine

THIS twelve-year-old girl was rescued from a fresh water swimming pool after falling off the diving board. She was in no acute distress when seen in the hospital emergency room. Rales were heard in her right lower lung. A chest roentgenogram was obtained and is shown in Figure one. Four hours later the patient developed a non-productive cough and began to complain of dyspnea. Rales were now present in both lungs. A chest x-ray taken at that time is shown in Figure two.

Figure 1

Figure 2

WHAT IS YOUR DIAGNOSIS?

1. Pulmonary emboli
2. Near drowning
3. Fulmonating viral pneumonia
4. Pulmonary hemorrhage

ANSWER: Near drowning.

During drowning or near drowning the victim struggles to hold his breath and invariably swallows a large volume of water. Vomiting results followed by aspiration and flooding of the lungs until asphyxia causes flaccidity. Occasionally, laryngospasm is present and prevents flooding of the lungs until flaccidity is complete. Uncommonly some victims die from asphyxia without water even entering the lungs. In others as asphyxia progresses, glottic muscles relax and the subsequent events are determined by the composition of the water which floods the lungs.

In fresh water drowning, large volumes of fluid can pass through the lungs as early as two minutes after submersion. Composition of the blood has been reported as much as 50 percent water. This marked hemodi-

lution results in massive hemolysis and dilutes the plasma concentration of sodium chloride, calcium, and proteins. Ventricular fibrillation, probably secondary to hypoxemia and low plasma sodium chloride, occurs as the terminal event. The physiologic end result of fresh water aspiration is hypoxemia, hemodilution, hypervolemia, hyponatremia, and hemolysis.

Sea water contains as much as 3.5 percent mixed salts and is strongly hypertonic compared to blood. When sea water is aspirated, these salts diffuse into the blood resulting in elevation of the sodium chloride and hematocrit levels. A rapid pulmonary edema develops and plasma protein is lost through the lungs. Hypotension and braycardia then result followed by asystole. The physiologic end result of salt water aspiration is hypoxemia, hemoconcentration, hypovolemia, hypernatremia, and hypoproteinemia.

The admission chest x-ray in this case shows bibasilar atelectasis with an infiltrate in the right lower lung which is consistent with aspiration (Figure one). The film taken four hours later shows the classic findings of pulmonary edema (Figure two). This would suggest that patients with the diagnosis of near drowning should be admitted to the hospital for observation. It is of interest to note that the heart size is not increased, although pulmonary edema is present. This is not an unusual finding in pulmonary edema secondary to aspiration, near drowning or fluid overload. The chest films on subsequent days showed interval clearing. On the day of discharge the patient's chest x-ray was normal.

Recommended Reading

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President's Page

PSRO - NHI
HOUSE OF DELEGATES ACTION

From the House of Delegates with over seventy members each with a differing view but generally with a common end in sight, a decision has been reached.

The officers and delegates of your Nebraska Medical Association, together with the members of your Ad-Hoc Committee on Professional Standards Review Organization, are alarmed at the tremendous future potential for mischief and harm to come from our government's declaration in law of PSRO. We are alarmed because we believe in the inevitability of increasing costs and decreasing quality of medical care under this governmental aegis. We are concerned also because of increasing federal encroachment into our lives, perhaps inappropriate standardization of medical care, loss of confidentiality of patient's records, and on, and on.

Despite these fears, the House with great reluctance, because it can see no viable alternative, has elected to follow the advice of its dedicated Ad-Hoc Committee. In substance this amounts to:

1. Creating a new free standing corporate entity "The Nebraska Foundation for Medical Care," whose chief immediate function will be the creation of a uniform utilization review potential for hospitalized patients in Nebraska.
2. Authorizing the Ad-Hoc Committee to proceed with implementation planning for this Foundation and for PSRO and their inter-relationships.
3. Seek funds for such activity by solicitation from voluntary subscribers. The House was adamant that no such funds could come from planning purposes from NMA membership assessment.
4. The Ad-Hoc Committee can be expected to return to the Spring House of Delegates for approval of operational plans for the Foundation and its PSRO relationships if voluntary funding can be secured to permit such planning. Without such monies an impasse may be reached which will stop the committee's efforts and require the Secretary of HEW to exercise his directional prerogatives under the existing law.

In separate but related action the House authorized the creation of a National Health Insurance Ad-Hoc Committee. Recognizing that PSRO must be an integral part of any NHI bill and that a bill of some sort seems imminent, the delegates have directed that action be taken. This action will be that of:

1. Studying the satus of all Federal NHI legislation.
2. Recommending to the NMA and its Officers appropriate steps to influence Federal legislation.
3. Recommending to the NMA such postures and attitudes by the Association as seem appropriate to such action as the Federal Congress may take.

I believe the House of Delegates has done its work well and in good faith. Theid deed is difficult. The members are to be congratulated for doing a job which they did not want to do, but seemingly could not in good conscience avoid doing.

James H. Dunlap, M.D.
President

Between Cases

From The Record Room.

Dictated. Resection ascending colon, diverticulosis sigmoid colon.

Typed. Resection ascending:, diverticulosis sigmoid : .

The Specialist.

Psychiatrist: the last doctor to take histories.

Which Way Did He Go?

Rectal exam negative: cannot find the little wart.

On Suicide.

Advice I read somewhere, on reducing the number of attempted suicides.

Listen more and prescribe less.

On Diastolic Pressure.

The BP was 115/90 by palpation of the radial artery.

The History.

Patient; schoolteacher with unequal pupils.

What Does It Mean?

Kwashiorkor: displaced child.

U. S. Health Care Bill, 1973:

Average American: $375
65 and over: $1,052

Good Advice.

Never purchase in the Market of Vain Regrets.

Anon.

True, True.

"It really gets me that a normal person never opens her mouth. It's only the crazies that'll talk to you."

Said by Girl, in The Hot L Baltimore, by Lanford Wilson.

Now Let's See.

He had a pain at the distal end of his alimentary canal.

On Equanimity.

I never lost a patient. A lot of them died, but I know exactly where they are.

C.M.

Section On Vein Stripping.

Patient had bilateral vein stripping in the right leg.

On TV Ads.

There are too many of them; they are unintelligent; they are repeated endlessly; and I do not know why they call them commercials. They are insulting: $99.99 is a hundred dollars, not ninety; and singing commercials are irritating. I will not buy anything advertised on TV, but I do owe them something. I get all my exercise from TV, because the engineers turn up the volume for the commercials, and I get up and turn it down when they advertise, and I get up and turn the volume up when the commercial is over.

Quote Unquote.

There is always that one man who says no.

Darrow.

I Know What He Means.

Facial defect, left calf.

Beautiful.

"a mass of Latin words falling upon the facts like soft snow, blurring the outlines and covering all the details."

Rostenberg.

On Editing.

Freedom of the press is guaranteed only to those who own one.

Liebling.

Department of Nutrition.

When a poor man eats a chicken, one of them is sick.

Proverb .

Section On Statistics.

One child in seven in the U. S. has a reading handicap.

On Hurting.

Pain is the greatest liar of them all.

Anon.

On Taking The Pulse.

Rate and rhythm even and regular.

On Research.

The researcher does not march with the procession, but he must do lonely, outpost duty.

Theobald Smith, M.D.

The Pill And The Explosion.

Every day, the world population increases by 213,000.

F.C.

The Letter Box

To the Editor:

I would appreciate your announcing in your next issue a series of two Professional Education TV programs on cancer. The American Cancer Society, Nebraska Division, in cooperation with Nebraska Educational Television, will air these one-hour programs and themes as follows:

Friday, November 15, 10:30 p.m., "Newer Developments in Cancer Surgery," Costas Assimacopoulos, M.D., and panel.

Thursday, December 19, 8:00 p.m., "Radiation Therapy," Prentiss M. Dettman, M.D.

Physicians will be able to phone-in questions during the program.

We believe that this will be a convenient method of assisting physicians in learning more about cancer and appreciate your cooperation in letting more physicians know about this series.

Sincerely,
John F. Foley, M.D.,
Chairman, Prof. Ed. Com.

To the Editor:

A recent break-through in post-exposure rabies immunization has been announced of which, we feel, the practicing physician must be apprised.

Early in September, 1974, Human Rabies Immune Globulin (HRIG) was released by the manufacturer, Cutter Laboratories. This preparation is intended for passive immunization of the person bitten by an animal suspect or proven rabid who is hypersensitive to horse serum. For the bite victim not sensitive to horse serum, the old preparation of equine origin is still appropriate.

The recommended dose is 20 IU/kg, 50% of which should be infiltrated into the tissues surrounding the bite wound; the rest injected intramuscularly. This must be followed by 21 injections of duck embryo vaccine (DEV) on a daily schedule and boosters on the 10th and 20th days following completion of the initial (daily) course to assure an adequate antibody response.

Physicians when in need of HRIG, may procure it by calling the Disease Control Division of the State Health Department (phone 402-471-2937) or the manufacturer through the Dallas Distribution Center (phone 214-631-6240).

The physician ordering this medication must be aware of the cost. 2.0 ml (recommended dose for an average child) is quoted at $35.00; 10 ml (recommended dose for the average adult) will cost $170.00.

The State Epidemiologist will review any bite incident in respect to indications for serum and vaccine. During office hours call 402-471-2937; after hours and weekends call 402-489-4227.

Respectfully submitted,
Henry D. Smith, M.D., M.P.H.
Director, Neb. St. Health Dept.

Down Memory Lane

1. The great increase in the use of motor driven vehicles has made head injuries one of the most important parts of emergency surgery.

2. The first question which occurs then in connection with the selection of a staff is this: Who shall select the medical staff? Shall it be a medical or non-medical authority? On the one hand we have professional rivalry, petty jealousy, legitimate competition to contend with; on the other, ignorance, religious prejudice and the necessity of making the hospital pay.

3. Many times we have seen operators who have numerous stitch abscesses.

4. It is true that a degree of pressure sufficient to produce choked disks reveals itself readily through ophthalmoscopic examination, but the mercury manometer or especially the later invention the water manometer gives absolute information as to the degree of intracranial pressure.

5. One of the frequent conditions the practitioner is called to diagnose, and treat, is pneumonia.

6. Fracture disabilities continue to play a tremendous role in permanent injuries.

7. The chapter in medicine which deals with homeopathy is from all appearances rapidly drawing to a close.

8. Hospital standardization on close analysis is shown to involve some principles which were quite revolutionary in our community.

9. Right here it might be said that the use of the catheter previous to pelvic operations might well be dispensed with.

10. Use and not abuse of the laboratory is desirable. Test tubes and electro-mechanical devices do not successfully replace brain function.

Nebraska State Medical Journal
November, 1924.

Picture Gallery

Fall Session of the Board of Councilors and House of Delegates held October 3-5, 1974. Photos marked (1) are of the Board of Councilors; (2) are of various reference committee activities and (3) are of the House of Delegates.

DR. DUNLAP
KEN NEFF
3

DR. BOBLEY
KEN NEFF
3

3

Welcome New Members

John J. Ferry, M.D.
8761 West Center Road
Omaha, Nebraska 68124

John W. Goldkrand, M.D.
University of Nebraska Medical Center
42nd and Dewey Avenue
Omaha, Nebraska 68105

E. K. Larson, M.D.
9 West 31st Street
Kearney, Nebraska 68847

Herbert B. Saichek, M.D.
9812 Bloomfield Drive
Omaha, Nebraska 68114

Woman's Auxiliary

Installation of Officers, April 30, 1974

The luncheon was held at the French Cafe in the Old Market Place. During the luncheon, the Nebraska Clothing Store presented a style show of spring and summer fashions. Following the luncheon, Mrs. Bosley introduced the ladies at the head table, the special guests, and the past presidents who attended. Mrs. Howard Liljestrand was introduced as the speaker.

Mrs. Kelley presented the awards for AMA-ERF to Buffalo County, Adams County, Lancaster County, Hall County, Dodge County, and Northwest County. Mrs. Bosley reminded the group that the national goal is $1,000,000 and this is the area on which she will give her report at the National Convention.

Mrs. Stanley Mountford presented the NMA Award to the Omaha Medical Society and Lancaster County for their contributions.

Burt-Washington County was cited for its 100% membership. They are also the newest organization. Scottsbluff also has 100% membership.

Mrs. McGinnis presented the Woman-of-the-Year Award to Mrs. Leland Olson of Omaha. The annual Merit Award was given to Mrs. Frank Tanner of Lincoln.

Mrs. Liljestrand installed the new officers by presenting each with a Vanda Orchid Lei and a kiss to represent the charge from Mrs. Liljestrand that the board serve with a feeling of love for each other and the Auxiliary.

Mrs. Bosley presented the new President to the group and Mrs. McGinnis presented Mrs. Bosley with the past president's pin. Mrs. McGinnis thanked the Convention chairman, Mrs. Denham Harman, who in turn thanked her committee.

The meeting was adjourned.

Mrs. John McCammond,
Secretary.

Our Medical Schools

November courses at U. of N.

The Center for Continuing Education of the University of Nebraska Medical Center will offer three courses in November of interest to physicians.

1. Current service issues in mental retardation will be the topic of a conference November 7 and 8.

Guest faculty includes Tom Miller, project director, Structured Correctional Unit, Eastern Nebraska Community Office of Retardation; Robert Perske, executive director, Greater Omaha Association for Retarded Children, Inc.; and Dale Samuelson, assistant superintendent for special education, Omaha Public Schools.

Course coordinators are Dr. Frank J. Menolascino, vice chairman of the department of psychiatry, and Robert Clark, consultant, division of preventive and social psychiatry, Nebraska Psychiatric Institute.

The registration fee of $35 includes luncheons and coffees and other amenities.

The course is acceptable for 9 prescribed hours by the American Academy of Family Practice.

2. On November 14 the Meyer Children's Rehabilitation Institute will present a course "The Developmental Origins of Behavior: Implications for the Management of the Child with Handicaps."

Guest speakers include Dr. Kevin J. Connolly, head of the department of psychology, University of Sheffield, England, and Dr. Martin C. Bax, consultant pediatrician, St. Mary's Hospital Medical School and research community pediatrician at the Thomas Coram Foundation, London.

The program qualifies for three prescribed hours by the AAFP.

The cost of the program is $10.

3. The second annual Midwest Conference on Allergic Diseases will be held November 21 and 22.

Guest faculty includes Dr. Hyman Chai, Children's Hospital Asthma Research Center, Denver; Dr. Richard Farr, National Jewish Hospital, Denver; Dr. Gerry Gleich, head, department of immunology, Mayo Clinic, Rochester, Minnesota; Dr. Joseph R. Rodarte, Mayo Clinic; and Dr. Sheldon Spector, National Jewish Hospital, Denver.

Dr. Irving Kass, head of the Regional Chest Center, is coordinator of the course, which is acceptable for 12 hours of AAFP credit.

All three courses will be presented in the Center for Continuing Education at the Medical Center in Omaha.

Dr. Beddoe named

Dr. Gladys Beddoe has been named assistant dean for post-graduate medical education at the University of Nebraska College of Medicine.

An associate professor of otolaryngology, Dr. Beddoe joined the Nebraska faculty in 1971 following a residency at Nebraska.

She is a fellow of the American College of Surgeons and a fellow of the American Academy of Ophthalmology and Otolaryngology.

Creighton and U. of N get together

Creighton University and the University of Nebraska Medical Center will share a department chairman for the first time.

Donald R. Bennett, M.D., will become Chairman of the Departments of Neurology for both schools effective November 1. At Creighton, the Medical School's executive committee gave its approval to Dr. Bennett's appointment and established neurology as a separate department. Dr. Joseph Holthaus, Creighton's Medical Dean, and Dr. Perry Rigby, N.U. Medical Dean, said the appointment is an important one. It is visible proof that the two universities can and

Welcome to Portland, Oregon for the 28th Clinical Convention

November 30-December 4, 1974

"In this age of specialization, there's a vital need for discussion of the broader implications of new-found knowledge. The 28th AMA Clinical is designed for that purpose...to bring together physicians of the various specialties to study and discuss the broader aspects of medicine as they apply to their practices."

Huldrick Kammer, M.D., Chairman
Council on Scientific Assembly

AMA
AMERICAN MEDICAL ASSOCIATION

For further details, write:
Circulation & Records Dept.
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

When diarrhea wrings the wedding belle...

It's all very well to counsel patience in diarrhea patients. There are times when relief of symptoms can't come too soon.

X-ray studies[1] in 16 normal subjects showed just how promptly the active ingredient in Lomotil does its work.

Lomotil retarded gastrointestinal motility particularly during the first three hours after administration. It continued its moderating action on the bowel for at least three hours more.

Physicians prescribe Lomotil more often than any other drug when the urgency for the control of diarrhea is most distressing.

1. Demeulenaere, L.: Action du R 1132 sur le transit gastro-intestinal, Acta Gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.

Lomotil®

TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
diphenoxylate hydrochloride . . 2.5 mg.
(Warning: May be habit-forming)
atropine sulfate . . . . . 0.025 mg.

Saves the Day

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion.* LOMOTIL IS NOT *AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests. HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries fo:
G. D. Searle & Co.
Medical Department Box 5110

Sign of a cold* sufferer

Time for Ornade®

Each Spansule® capsule contains 8 mg. Teldrin®
(brand of chlorpheniramine maleate);
50 mg. phenylpropanolamine hydrochloride;
2.5 mg. isopropamide, as the iodide.

Fast relief of upper respiratory congestion and hypersecretion* with convenient b.i.d. dosage.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Indications**
Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Possibly effective: For relief of upper respiratory tract congestion and hypersecretion associated with vasomotor rhinitis and allergic rhinitis, and for prolonged relief.

Lacking in substantial evidence of effectiveness: For relief of nasal congestion and hypersecretion associated with the common cold and sinusitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Warn patients of possible additive effects with alcohol and other CNS depressants.

Usage in Pregnancy: In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

Effect on PBI Determination and I^{131} Uptake: Isopropamide iodide may alter PBI test results and will suppress I^{131} uptake. Substitute thyroid tests unaffected by exogenous iodides.

Precautions: Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.

Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

Supplied: Bottles of 50 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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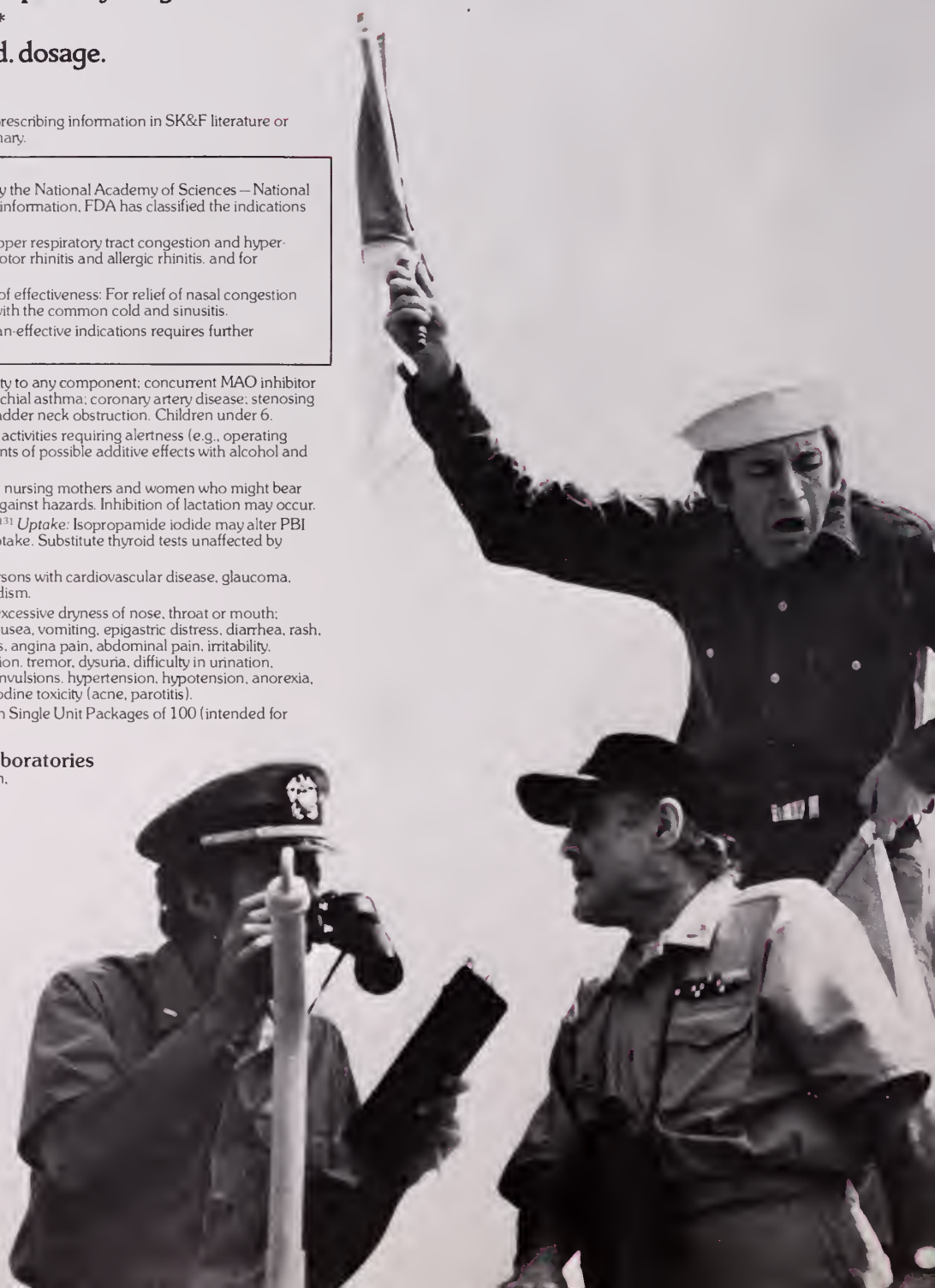
Philadelphia, Pa. 19101



are working together to avoid duplication. The two said they are also discussing other medical specialty areas in which combined programs might be advantageous.

Dr. Bennett is now associate professor of neurology at the University of Utah College of Medicine in Salt Lake City. Before joining the Utah faculty, Dr. Bennett was director of the neurology branch of the U. S. Air Force School of Aerospace Medicine at Brooks Air Force Base.

Dr. Ruegamer appointed

Dr. William Ruegamer has been named associate dean of the School of Allied Health Professions at the University of Nebraska Medical Center in Omaha.

Dr. Ruegamer has been chairman of the department of biochemistry at Nebraska since 1968. Previously he was professor and acting chairman of the department of biochemistry at the State University of New York College of Medicine in Syracuse.

U. of N. appoints neurology head

Dr. Donald R. Bennett has been named chairman of the department of neurology at the University of Nebraska Medical Center. He succeeds Dr. F. Miles Skultety, who has become an associate dean for clinical affairs.

Dr. Bennett has been an associate professor of neurology at the University of Utah College of Medicine. Before that he was the director of the neurology branch of the U. S. Air Force School of Aerospace Medicine, Brooks Air Force Base.

A graduate of the Virginia Military Institute, Dr. Bennett received his medical education at the Georgetown University School of Medicine. He interned at the University of Iowa Hospitals and received his residency training at the University of Wisconsin.

He is certified by the American Board of Psychiatry and Neurology.

Dr. Skultety new dean

Dr. F. Miles Skultety has been named the new associate dean for clinical affairs at the University of Nebraska College of Medicine.

The neurosurgeon has been on the Nebraska faculty since 1966 as the Shackleford Professor of Neurosurgery and Neuroanatomy and chairman of the section of neurosurgery.

In 1973 Dr. Skultety founded the pain center at the University of Nebraska Hospital, one of only five in the nation. He has since directed its activities as well as serving as interim chairman of the department of neurology.

Dr. Skultety has authored numerous scientific papers and holds membership in the Congress of Neurological Surgeons, American Association of Neurological Surgeons, American Neurological Association, Society of Experimental Biology and Medicine and is a fellow of the Royal Society of Medicine.

He succeeds Dr. Francis Land who has accepted a position at the University of New Mexico.

I Remember

THE CATASTROPHE

I hope you will not mind this title. It all happened when I was an intern, and being an intern is one of the happiest times of a doctor's life. I was on ambulance and emergency room duty, only we said we were riding ambulance, or riding the bus.

I was second on call, and enjoying a late breakfast, when the call came in. The hospital cat was having kittens, or wanting to, and there was a bit of a problem. There was a breech presentation, and it would not deliver. They had called the ambulance driver, and he said he didn't know what to do, they were to call me.

The cat was in the kitchen, and they had pulled off the tail of the kitten she was trying to deliver. She had been at it for hours, I think, and the one knocking at the door was dead, I was sure. Someone called for ether, but I was fresh out of school, and I remembered what ether does to a cat. I had seen one bite through a student's shoe and foot in the laboratory, when he unwittingly let it out of the bell jar.

So I figured what was what on a cat, and delivered the kitten, and three live kittens quickly followed. And I was the hero of the kitchen for a long time after.

If it had been a dog, I could not have chosen so apt a title. I had a Boston terrier once, and they get into trouble like that, but my bulldog was a male. And my patient was a cat.

F.C.

Coming Meetings

CRIPPLED CHILDREN'S CLINICS—
November 9 — Norfolk, Elks Lodge
November 30 — Ainsworth, Elm Grade School
December 14 — North Platte, Elks Lodge

OMAHA MID-WEST CLINICAL SOCIETY — 42nd Annual Postgraduate Assembly, November 11, 12, and 13, 1974, Omaha Hilton Hotel. Write to: (Mrs.) Mary E. Pilloud, Executive Secretary, 1040 Medical Arts Building, Omaha, Nebraska 68102.

NEBRASKA HIGH SCHOOL TEAM PHYSICIANS SEMINAR — November 16, 1974, Hilton Hotel of Lincoln, Lincoln, Nebraska.

AMERICAN ASSOCIATION FOR CLINICAL IMMUNOLOGY AND ALLERGY — Annual Meeting; Pier 66, Ft. Lauderdale, Florida, November 21-24, 1974. Write to: John L. Dewey, M.D., P. O. Box 912, DTS, Omaha, Nebraska 68101.

AMERICAN CANCER SOCIETY — National Cancer Institute — National Conference on Advances in Cancer Management; Part I, Treatment and Rehabilitation, November 25-27, 1974, Waldorf-Astoria Hotel, New York City.

AMERICAN MEDICAL ASSOCIATION — 28th Clinical Convention, November 30-December 4, 1974, Portland, Oregon.

NEBRASKA MEDICAL ASSOCIATION — Annual Session, April 27-30, 1975, Hilton Hotel, Lincoln, Nebraska.

AMERICAN CANCER SOCIETY — National Cancer Institute — National Conference on Advances in Cancer Management; Part II, Detection and Diagnosis, May 1-3, 1975, The Denver Hilton, Denver, Colorado.

AMERICAN MEDICAL ASSOCIATION — Annual Convention, June 15-19, 1975, Atlantic City, New Jersey.

NEBRASKA MEDICAL ASSOCIATION — Fall Session, October 17-19, 1975, Omaha, Nebraska.

WashingtoNotes

Shortages: slums and rural areas

The Senate has overwhelmingly passed legislation that would require one fourth of all medical and dental school graduates to spend at least two years in the nation's slums and rural areas where there are shortages of physicians.

Earlier the Senate voted down a much more sweeping bill sponsored by Senator Edward Kennedy that would have required mandatory federal service for all health professions students and national licensure and relicensure for physicians and dentists.

The bill finally approved by the Senate was stripped of most of the controversial provisions of the original Kennedy bill and was a victory for the AMA, the American Dental Association, and the Association of American Medical Colleges.

The Senate bill calls for a three-year extension of present federal programs for aiding medical education at a total cost of about $2 billion. Capitation grants for medical schools would be continued at a high level despite the administration's request for a cutback.

The Senate bill does not contain the original requirement for a federally-appointed National Council on Postgraduate Education with 10 regional councils designed to deal with allocation of specialty training slots and foreign medical graduates.

Another casualty of the Senate voting was the proposal for federal standards for licensing and relicensing physicians and dentists.

Immigration standards would be tightened to restrict the number of foreign medical graduates under the Senate bill.

National health insurance

Undaunted by collapse of the National Health Insurance measure in the House Ways and Means Committee in late summer, Senator Russell Long (D., La.), is forging ahead with plans to ram a bill through the Senate in the strained atmosphere of a "lame duck" Congress. Long is Chairman of the Senate Finance Committee and sponsor along with Senator Abraham Ribicoff (D., Conn.) of a NHI plan featuring Social Security financed and operated catastrophic health insurance plan for all. The Long Ribicoff bill enjoys the official support already of 25 Senators and rates some chance of Senate passage.

Manpower: federal scholarships

A House subcommittee has approved a counterpart bill to the Senate manpower legislation that would establish federal scholarships intended to increase the number of doctors in the nation's rural areas and urban slums where there are doctor shortages.

The bill authorizes $240 million over three years for National Health Service Scholarships paying $9,200 to $9,500 a year to cover the cost of a medical education.

In return, the scholarship recipients would have to spend two to four years serving in areas with doctor shortages. Non-scholarship students who volunteer to practice in

areas with doctor shortages would receive a guaranteed income of $28,000 a year until they get their practices started.

The bill would also give medical schools a grant of $2,100 a year for each student — $400 less than the schools now receive.

But any graduate who does not practice in an underserved area would have to repay the government the money given to the medical school.

The House bill differs sharply from the Senate version, particularly the Senate provision forcing medical schools to have one fourth of their classes on federal scholarships requiring two years of practice in underserved areas.

Medical costs

President Ford's long-heralded summit economic conference produced relatively little talk about health care costs and inflation, despite the fact that HEW Secretary Weinberger has of late frequently sounded such an alarm.

Nor was there any indication during the Washington parley that the Administration was considering controls at this time.

AMA President Malcolm C. Todd, a delegate to the summit conference, said that he agreed with the President with respect to avoiding controls at this time — "particularly discriminatory cost controls."

While pleased that President Ford had not called for wage-price clamps by the federal government, Dr. Todd at the same time criticized the Administration for "singling out" health by "annualizing" monthly consumer price index levels. The practice of projecting the yearly increase on the basis of what happens during one month or several months has been followed only on "health" by the HEW Department so as to bolster its contention that the health segment should be isolated for controls, Dr. Todd charged.

The AMA President noted that in the past three years physicians' fees have risen 17.6 percent compared with 22.9 percent for the economy as a whole and, for example, 32.9 percent for legal charges.

Suggested steps to curb medical costs, listed by Dr. Todd, were pre-admission testing; expansion of ambulatory care services; earlier discharge from hospitals; avoidance of unnecessary hospitalization; reducing wasteful testing, prescribing and treatment; and decreasing the cost of malpractice insurance.

HEW and AMA

A wide range of health care related subjects were discussed at a recent meeting between an AMA delegation and HEW Secretary Caspar Weinberger.

Malcolm Todd, M.D., President of the AMA, said the Secretary and his aides were told that the AMA desires the best possible national health insurance (NHI) program that can be worked out, but cautioned against any hurry-up approval in an emotionally-charged Congress late in the session.

Dr. Todd said he emphasized that the number one problem facing the nation at present is inflation and that therefore any NHI program should have a minimal impact on this problem. AMA officials urged that NHI be kept outside of the Social Security Administration.

Reserpine and hypertension

The Food and Drug Administration is planning a letter to physicians alerting them to a series of studies to be published, that finds a higher-than-normal incidence of cancer of the breast among women age 60 and older who have been treated with reserpine for high blood pressure. A panel of experts appointed by the HEW Department will review the data.

Oral diabetic preparations

FDA has indicated to Congress it will order warning labels placed on oral diabetic preparations when a new study of the drug's safety and efficiency is published soon.

Alexander Schmidt, M.D., FDA Commissioner, told the Senate's Monopoly Subcommittee headed by Senator Gaylord Nelson

that the FDA endorses a 1970 study by the University Group Diabetes Program which found that the drugs (tolbutamide and phenformin) were linked with a heart disease death rate twice as high as for diabetics taking insulin or no drug at all through diet.

Major opponent of relabeling is the Committee on the Care of the Diabetic, composed of some 180 physicians. The issue has proved a serious controversy among specialists in the treatment of diabetics.

Books

Books reviewed

Review of Medical Pharmacology, by Frederick H. Meyers, Ernest Jawetz, and Alan Goldfien; 7 in by 10 in; 721 pages; limp cover; $10.50; Lange Medical Publications, Los Altos, California; 1974.

This is the fourth edition of the Review, which first appeared in 1968. The three authors are all MDs, and are all professors at the University of California School of Medicine in San Francisco. The book is divided into eight parts, and further into 66 chapters. There is a 20-page appendix, and a 27-page index.

It is well written and well printed, and full of figures and illustrations.

I recommend it, even though they say that my decaffeinated coffee has more caffeine than I thought it did.

F.C.

Handbook of Medical Treatment, edited by Milton J. Chatton, M.D.; 640 pages; $7.50; soft cover; published 1974 by Lange Medical Publications, Los Altos, California.

This can honestly be called a handbook, since it measures 4¼ by 7 inches, even if it is a full inch thick. The first edition of the Handbook appeared in 1949; this is the 14th edition. There are 18 authors (the Editor is one) and 23 chapters. There is a long and therefore useful index, and an appendix; there are many tables.

The chapters are well written, and the type is easy to read. It is a good handbook, and it is worth twice the asking price.

F.C.

Manpower Issues and Voluntary Regulation in the Medical Specialty System, by Herbert J. Lerner; 187 pages; $5.95 paperback; published 1974 by Prodist, New York.

The fact has not been stressed "that M.D. degrees and licenses to practice medicine are received only halfway through what has become the routine undergraduate-plus-graduate period of medical education." This is a study of the distribution of physicians by specialty and of manpower concerns of the specialties. Whether you agree with the concept of the project, it is well written and easily read.

Did you know that Washington, D.C., has the most specialists per population in just about every medical field? Nebraska, I find, does not appear in the list of states with fewest specialists per population in any field, and the book analyzes some 21 specialties, six of which begin with the letter P.

I found an interesting table (32) that shows that there are 114,400 board-certified specialists (I think he means in the U.S.) and 183,607 self-designated specialists, so that the former is only 62.3% as large as the others. They are not inclusive, I do not think, because for most fields, self-designated are larger than board-certified; but for only one (thoracic surgeons), the certifieds are greater. Anyway, there is a small arithmetical error in the table, but it is not important. It's from the AMA.

There is no index, which is too bad, but it is a book you might like to read. The foreword is written by John H. Knowles, M.D., President of the Rockefeller Foundation.

F.C.

Books received

How to Use Statistics, by John Ottoson; paper; 28 pages; published 1974 by National Fire Protection Association, Boston, Mass.

From Medical Police to Social Medicine, Essays on the History of Health Care, by George Rosen; 327 pages; paperback $5.95; published 1974 by Science History Publications, New York.

Medicinews

Senate passes health services act

The Senate has passed S. 3280, the Health Services Act of 1974, extending assistance to the migrant health center, the community mental health center and the community health programs. Block grants would be provided to the states to be used for comprehensive public health services. The bill further provides federal funds to assist the establishment and initial operation of public and private non-profit home health agencies and training grants for home health personnel. A similar bill had already passed the House, and the legislation will now proceed to conference under the designation H.R. 14214.

Medicare

Beginning January 1, 1975, a person who goes to the hospital under Medicare will be responsible for the first $92 of his hospital bill. The present deductible of $84 will remain in effect for Medicare hospital admissions during the rest of this year.

In announcing the $92 deductible, HEW Secretary Caspar W. Weinberger said this amount is equivalent to the average cost of one day of hospital care. The deductible is the part of the hospital bill which the beneficiary is responsible for the first 60 days of hospital care in each benefit period. Medicare pays the rest of the costs of covered services. At the present time the average hospital stay under Medicare is about 11½ days, at a cost of over $1,000.

Secretary Weinberger said the increase in the deductible results from continuing increases in hospital costs. He noted that the law requires an annual review of hospital costs under Medicare and an adjustment of the portion of the bill for which a Medicare beneficiary is responsible, if these costs have risen substantially. The law provides a formula for determining the amount of any adjustment in the deductible amount.

The hospital deductible amount, Secretary Weinberger explained, is like the deductible amounts specified in many auto insurance policies, where the car owner pays the first $50 or $100 on a repair bill, and the insurance policy covers the rest.

When the hospital deductible amount changes, the law requires comparable changes in the dollar amounts that a Medicare beneficiary pays toward a hospital stay of more than 60 days, or a skilled nursing facility stay of more than 20 days.

When a Medicare beneficiary has a hospital stay of more than 60 days, he will pay $23 a day for the 61st through the 90th day, up from the present $21 per day. If he has a posthospital stay of over 20 days in a skilled nursing facility, he will pay $11.50 per day toward the cost of the 21st day through the 100th day, up from the present $10.50 per day.

If a beneficiary uses his "lifetime reserve" days, the extra 60 hospital days a beneficiary can use when he needs more than 90 days of hospital care in the same benefit period, he will pay $46 for each reserve day used, instead of the present $42 per day.

Anti-diabetic drug hearings held in senate

The Senate Monopoly Subcommittee held three days of hearings September 18-20 on oral antidiabetic (hypoglycemic) drugs. The hearings, part of the series of Senate hearings on competitive problems in the drug industry, revolved around the University Group Diabetes Program (UGDP) study which concluded in 1970 that oral antidiabetic drugs were both ineffective and dangerous. Witnesses on the first day of hearings were members of the UGDP who were involved with the study on oral antidiabetic drugs. The panel of witnesses defended the validity of the UGDP study, called for mandatory warnings on hypoglycemic drug labels, and suggested further trials to study the long-term effects of such drugs. Dr. Thomas Chalmers, President of the Mount

Sinai Medical Center and Chairman of the UGDP Policy Advisory Board said, "The new FDA labeling (for hypoglycemics) should be strong enough to warn all physicians that they are distinctly putting their patients at risk by using oral agents when diet or insulin will suffice."

Senate adopts compromise manpower bill

By a vote of 81-7 the Senate adopted a three-year, $2 billion extension of federal aid to medical education. The bill, as passed, is a compromise measure introduced by Senator Beall (R., Md.), and it was adopted after the Senate specifically rejected the $5.2 billion, 5-year program, sponsored by Senator Kennedy (D., Mass.). In the course of the floor debate an amendment by Senator Proxmire (D., Wis.) prohibiting FDA control over certain dietary supplements was also adopted.

Major deletions from S. 3585, the Health Manpower Shortage Area Assistant Act of 1974, were proposals for mandated service for all health professions students and federal licensure of physicians and dentists. The Senate-passed bill includes the extension of student loans of up to $4,000 annually to students who agree to serve in shortage areas or institutions. Loan recipients would be required to practice family medicine, general pediatrics, or internal medicine as a condition for loan forgiveness. The loan forgiveness would be at a rate of 25% per year. The bill also extends the National Health Service Corps Program, including a scholarship plan and special bonus pay provisions. Capitation grants would be continued for schools of the health professions, but the level of capitation funding would gradually decrease from $2,500 a year to $2,200 unless the institution demonstrated that no less than 50% of its graduates were serving residencies in family medicine, general pediatrics, or internal medicine. In order to qualify for capitation funding at least 25% of the students accepted for admission would be required to volunteer to practice for two years in an underserved area or institution as practitioners of family medicine, general practitioners or internal medicine. Individuals who failed to meet their service obligation would be required to pay back, on a two-for-one basis, the capitation amount attributable to their education together with any direct assistance which they received. Limitations would be placed upon the number of postgraduate training positions open to foreign medical graduates, and the immigration laws would be modified to bar foreign medical graduates unless they have passed Parts I and II of the National Board of Medical Examiners Examination or the Federal Licensing Examination, demonstrated competency in oral and written English and demonstrated that their entry would not create a surplus of practitioners in a particular specialty or geographical area.

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PHYSICIANS NEEDED — We had good results with the previous advertisement but still recruiting for Internal Medicine, General Practice, Adolescent Medicine or Adolescent Pediatrics. Salaries competitive and flexible in upper 20's or low 30's. Excellent fringe benefits and working hours. Must have sincere interest in working with young adults. If interested, call or write K. O. Hubble, M.D., Acting Executive Medical Director, University Health Center, Lincoln, Nebraska 68508. University of Nebraska is an Affirmative Action Equal Opportunity Employer.

FOR SALE — Good used examining table with matching cabinet, waste receptacle and stool. Steel desks, chairs, card files, scales, refrigerators, dictaphone, electrocardiograph, lab equipment. Contact Howard Wold, M.D., 613 N. Washington, Madison, S.D. 57042. Phone 605-256-4519.

PHYSICIAN RETIRING — Office and all equipment available. Only physician in county. Contact Box #52, NEBRASKA MEDICAL JOURNAL, 1902 First National Bank Building, Lincoln, Nebraska 68508, if interested.

WESTERN NEBRASKA TOWN on 180 and U.S. 30 needs two physicians (G.P. or family practice). Fully equipped hospital. Help available in procuring clinic facilities. An ideal community to raise families. Agriculture is principal industry. Contact: Ronald L. Howerter (308) 874-2292 or (308) 874-2610.

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RURAL PHYSICIAN is interested in having a physician join him in a north-central Nebraska practice. If interested, contact Box #48, NEBRASKA MEDICAL JOURNAL, 1902 First National Bank Building, Lincoln, Nebraska 68508.

115 TACTICAL CLINIC, Nebraska Air National Guard, would appreciate the donation of medical or office equipment for its new facility. Contact D. Mabeus, M.D., or F. Koranda, M.D., ANG Base, Lincoln.

IMMEDIATE OPENING — For Ob-Gyn. and Internal Medicine specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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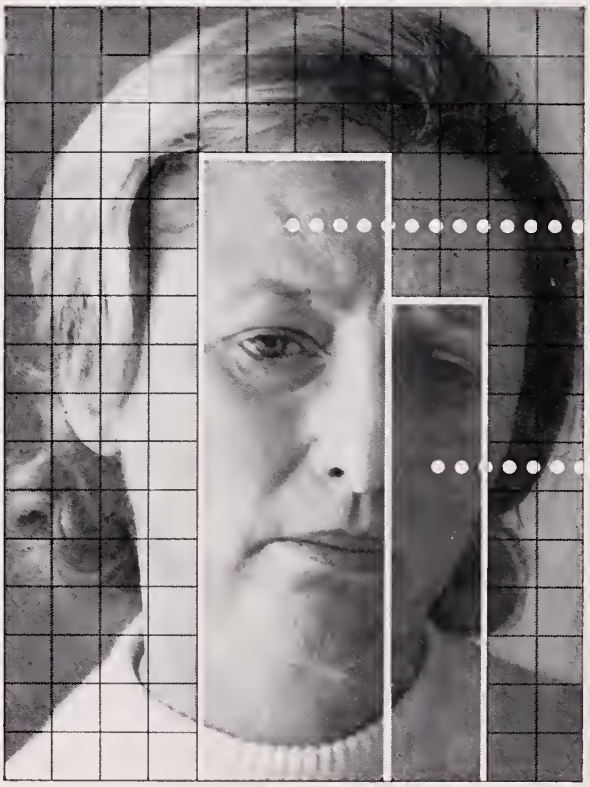

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

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in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The Nebraska Medical Journal

EDITOR — FRANK COLE, M.D., 1845 "F" St., Apt. 1, Lincoln 68508 DECEMBER 1974 VOL. 59, NO. 12
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Our Medical Schools . . .

Family therapy

The Center for Continuing Education at the University of Nebraska Medical Center will offer a course in family therapy on Thursday and Friday, January 23 and 24.

Registration fee is $60. The course is acceptable for 14 hours of credit with the American Academy of Family Practice.

Coordinator of the course is Dr. Norman West, assistant professor of psychiatry. Other course participants will be members of the department of psychiatry at the Medical Center.

Health service administration

Two Creighton University physicians, Drs. Frank Shepard and Paul Reichstadt, have completed training as local resources physicians for the National Health Service Corps, the Indian Health Service and the Bureau of Medical Services. All are programs within the public health services of the Health Service Administration. Persons with questions about the organizations mentioned are urged to contact Dr. Shepard or Dr. Reichstadt.

Dr. Andrews to talk

Dr. Richard Andrews, Assistant Medical Dean, has been invited to present the 1975 Maiben Lecture at the Nebraska Academy of Sciences annual meeting in April. Dr. Andrews will speak on the biological control of rat populations using antifertility methodology. The group's annual meeting is being held at Nebraska Wesleyan University in Lincoln.

Medical moral matters grant

The Rev. James J. Quinn, S.J., Associate Professor of Philosophy and Creighton University's Program Director for Humanities in the Health Sciences, has received a $30-thousand grant from the National Endowment for the Humanities to support research on medical moral matters.

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Medicinews . . .

Medicare handbook

Commissioner of Social Security James B. Cardwell has announced that a new edition of *Your Medicare Handbook* will be mailed by November 30 to more than 23.5 million people covered by Medicare health insurance. Doctors, hospitals, skilled nursing facilities, home health agencies, and health insurance organizations that handle Medicare claims also will receive the new handbook.

The new edition is a result of major amendments made in the Medicare program in the past 2 years. The new handbook explains in detail how Medicare hospital and medical insurance work. It tells what kinds of care are covered, who can provide care, and how much Medicare pays.

The handbook includes expanded tables of covered and noncovered services and supplies, and describes conditions that must be met for each type of covered care.

A completely new format is the result of studies conducted by the Social Security Administration with beneficiary groups and health care providers, according to the Commissioner.

A completely new format is the result of studies conducted by the Social Security Administration with beneficiary groups and health care providers, according to the Commissioner.

The handbook is 5¼ x 8 inches, smaller and easier to handle than previous editions with cross references and an index which will help people locate information.

Institutions and professionals who want additional copies of the new handbook can get them at any social security office or from the health insurance organization that handles Medicare claims in their area.

Medicare helps pay the health care bills of people 65 and over, of disabled people under 65 who have been entitled to social security disability benefits for at least 24 consecutive months, and of many people with chronic kidney disease.

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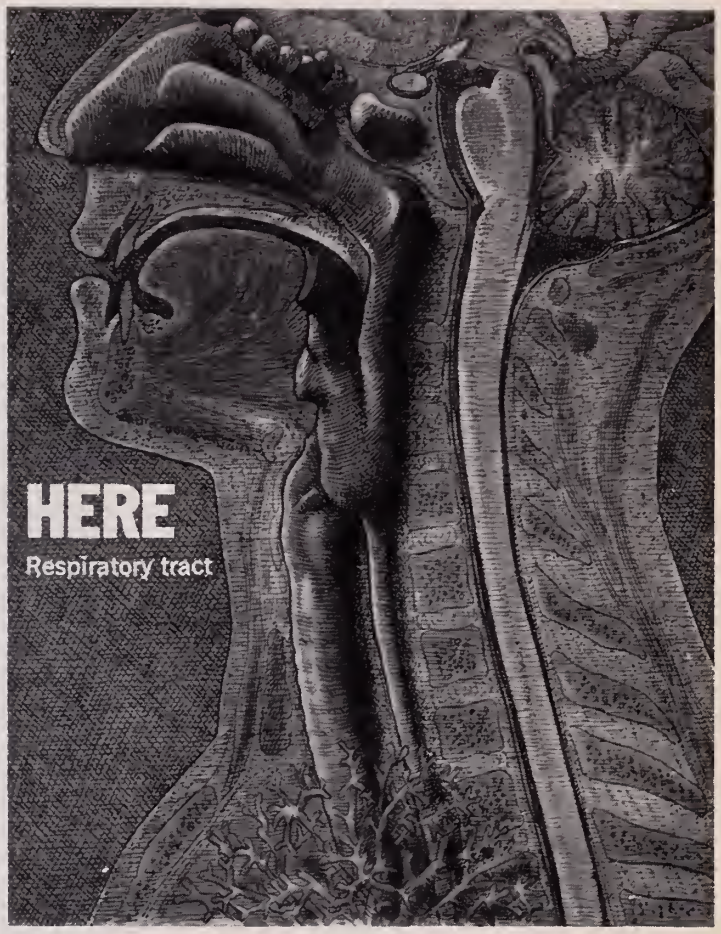

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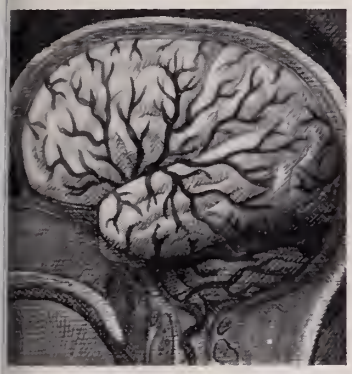

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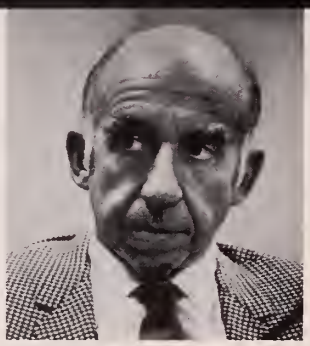
Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this countr there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihoo on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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P·M·A

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ABSTRACTS CONDENSATIONS SUMMARIES AND CONCLUSIONS

I do not know why abstracts are printed right along with medical articles, except that I find myself reading them, too. It is a chore the author would like to escape, and it keeps many a reader from reading the article. It is like printing the solution to a whodunit together with the story.

The abstract is now printed at the beginning of the article, and the intent of the author and publisher is to discourage you from reading the article. For even if the study is one that interests you, you may find it silly to read the whole article when you already know what the author is going to say.

If you read the abstract or the summary and then continue with the text and unwittingly go on to the conclusion, you begin to feel as though you had just watched a football game on television, because if you sit through all the instant replays, you are trapped into watching two games, even if they are the same game.

Every author feels that what he has done is breathtaking and earthshaking and even throughbreaking. So he begins with the year one and tells you not merely what he has done, but what its impact will be on medicine. If the editor is then given over to meditating on the same subject in the same issue, you must grit your teeth to escape.

But I read them, too, and I do not mean to do away with them. They are handy, and they make for quick reading at the breakfast table.

F.C.

ON GUESSING YOUR WEIGHT

All those height-weight tables leave me cold, especially if I am to step on the scale fresh out of the shower; there is too much looking up to do. You have to know if you are dressed or not, and if the table is meant for men or for women, although a glance at the mirror will take care of both problems.

You must contend with height with shoes, indoor clothing, and with small and medium and large frame. And so I have come up with a simple way of doing it in your head. You should weigh, if you are a man, and unclothed, 4 times your height (in inches) minus 135. Or 4 times your height over 5 feet, plus 105.

If your frame is not medium, add or subtract 7 pounds.

If you are a woman, it's 10 pounds less.

Since your height and frame do not change, just figure all this out once and try to remember the answer.

F.C.

THE BATHTUB AND THE EDITOR

The bathtub is one of the strangest inventions known. I said once that I had not had a bath in years, which is true, but I shower every day. In the tub, you loosen the dirt that has accumulated on the lower half of you, and then you sit in it.

The tub is enervating, and the shower is innervating; in the shower you stand and get clean, and sing if you are any good at singing, which I am. But I have begun to bathe, and I find that the tub-bath has other values. You stand in the shower for only minutes, but you sit in the tub, which is relaxing, since it takes no muscular activity to sit; and you stay for long periods of time, with no book or television to occupy your mind.

You have been given over to tranquilizing and to meditation, and they are both good. I suggest that tub bathing be prescribed for these beneficial effects, and while you cannot write in the tub, unless you have an under-water-writing pen, you can compose editorials.

I suppose you could sit in a shower, but it seems funny. I think the tub bath should

be followed by a shower, unless you bathe at night, and want to be drowsy, not stimulated. Some get clean first, *then* they get in the tub.

F.C.

SHOULD DOCTORS SMOKE?

Assuming that smoking tobacco is bad for you, it is the physician's duty to tell this to the patient when asked or when it is pertinent. The doctor may, if he likes, tell all his patients, and even put up signs in his office.

A case may be made for the unfortunate sufferer in whose presence others are smoking, but aside from those who feel that living dangerously is worth it, smoking may be unwise, but it is neither unethical, immoral, nor illegal. The physician has discharged his duty when he has informed his patients. If they then choose to smoke, they may and they will. I do not smoke, but if informed patients choose to do so, I do not see why the doctor may not smoke as well.

There may be something incongruous about a doctor smoking while he advises his patients not to, and while he has signs in his office to that effect, but it is not at all senseless. I simply do not see why the physician must feel it his duty to set an example by doing what he does not believe in, as long as he injures no one else.

Doctors do smoke, maybe as much as they ever did, and possibly as much as nondoctors. I discovered this at a medical meeting, where I whiled away part of the time by counting the smokers.

A doctor once asked me why we ran a tobacco advertisement in the Journal (we don't any more), and he was filling his pipe at the time.

The physician may not believe that smoking is harmful, in which case he will smoke as much as he wants to. But if he accepts the idea that it is not innocuous, I do not see why he must take his own advice. Let him have his cocktail before dinner, and smoke after it, if he likes. He has done his duty when he has informed his patient, and indeed, I think the patient has been informed before he comes to see the doctor.

What *is* silly is the government, telling people smoking is bad for them, while it subsidized the tobacco industry.

F.C.

ON CONDITION

Condition is like empathy, it's an old word in a new use, and it's overworked and meaningless. Patients speak of a liver condition, but we have learned to translate that into hepatic insufficiency. Meanwhile, I have just read that a hospitalized patient is in poor condition.

Now I have known patients whose condition was critical, whatever that means, and sometimes the condition was serious, or it may have been dangerous. Occasionally, a communique, which used to be called a bulletin, which used to be called a report, says that the condition is deteriorating; I suppose that means worse.

But to say that the condition is poor means giving up nice big words we learned in school which were a refuge behind which we looked wise whatever happened to the patient. Weather predictors say 20 percent chance of rain, so they can't go wrong.

Anybody knows what poor means.

F.C.

A DELUGE OF DYING WITH DIGNITY

One dies alone, the French say, and nobody I know has ever experienced dying. When someone is on the verge of breathing his last, two questions are raised: should you tell the patient; and should you let him die if he wants to die or if the outcome is certain and if he is in irreversible coma and if the expense is great.

You can tell the expiring patient that he is going to die, or you can just answer his questions, or you can hold out whatever rays of hope there are to be held out

honestly, or you can offer hope without a strict regard for truth.

If a dying patient wants to die, or his mind is forever gone, and where the financial burden is severe and all to no purpose, one can let him die or not.

Now that is all you can do: tell him or not, and let him die or not.

But we are being deluged with books and articles on the subject. Tell him the truth, they say. And let him die, or pull the plug, if it is hopeless and he is in pain, and it is costly, and he wants to die.

There is too much being written about dying, and I thought I would add to the list. And after me, the deluge, as the French king said.

F.C.

LET ME COUNT THE WAYS

Unfunny things *are* funny, and counting bloody sponges when the patient's belly is open from guggle to zatch, as a surgical friend says, can be one of them. Once we were 17 sponges short and we got down on our knees to look for more. And on another occasion we were one sponge over. So they all got down on their knees, and if they had found a missing sponge, we would have been *two* over. We came across a couple of gory things that had once been halves of a sponge, which solved the problem. But when we counted again, we were *three* over.

We're missing a needle: count them again.

We did, and the count is correct: fine, now we can close. The first count was probably accurate, but the last one was what we wanted to hear.

He has appendicitis; get a white count. It's 5,000: I don't believe it; repeat the count. It's 10,000: I thought so, call the O.R.

Fifteen references are enough for an article, but the count is in the hundreds now. They may help one in a thousand readers and impress the same number, but I think the author's work cannot be original if 300 others preceded him.

When I see a list of references including eight articles by Dr. Syzygy, I look at the top of the page, and guess who wrote the article? Sure enough, our old friend Dr. Syzygy.

F.C.

Sodium Retention Accompanying Insulin Treatment of Diabetes Mellitus — C. D. Saudek et al (818 Harrison Ave, Boston 02118). Diabetes 23:240-246 (March) 1974.

Five diabetics with varying degrees of decompensation were hospitalized in a metabolic ward. Prior to the initiation of insulin therapy, urinary sodium excretion was measured while sodium intake was regulated. Insulin therapy induced the expected fall in plasma glucose, free fatty acids and ketones, but in addition caused a striking change in urinary sodium excretion even though sodium intake was kept constant. The antinatriuretic effect of insulin could not be accounted for solely by the reduced glucosuria or ketonuria. Insulin's antinatriuretic effect warrants consideration when treating patients with cardiac or renal failure.

Vinblastine Treatment of Hodgkin Disease— R. E. Lenhard, Jr., et al (Johns Hopkins Hosp, Baltimore 21205). Johns Hopkins Med J 134:211-217 (April) 1974.

Vinblastine, 0.3 mg/kg, was given every two weeks for four months to eight patients with stage IIB and stage IV Hodgkin disease who had received no prior therapy. There was a complete remission in three patients and a partial remission in two. Moderate bone marrow toxicity (no WBC count >1,000) occurred in three patients. Marked neurotoxicity was seen in all five patients who obtained a tumor response, but not in those whose Hodgkin disease failed to respond. In addition, several patients who experienced marked neurotoxicity following vinblastine therapy were later able to receive the usually more neurotoxic drug, vincristine, without developing neuropathy.

Cancer Genetics: Urological System Part II*

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Wilms' Tumor

WILMS' tumor accounts for approximately six percent of all renal malignant neoplasms, and about three fourths of these tumors occur in children under the age of four years.[1] This malignant neoplasm has an insidious clinical course and unfortunately may reach a massive size before the first symptoms are recognized.

Wilms' tumor is associated with a number of congenital anomalies. The most frequent association is with aniridia.[2-4] Other congenital anomalies include hemihypertrophy, pigmented nevi, hemangiomas, horseshoe kidneys, cryptorchidism, hypospadias, undescended testes, bilateral small fibrous ovaries, recurved pinna, microcephaly, mental retardation, and multiple neurofibromatosis. Associated cardiac anomalies include tetralogy of Fallot with patent foramen ovale (one case), aortic stenosis (one case), patent ductus arteriosus (two cases), and patent foramen ovale in two patients at age four and six years.[5]

Lynch and Green[6] presented a patient with bilateral Wilms' tumor and congenital abnormalities of the heart (transposition of the great vessels and Ebstein's anomaly) confirmed at autopsy. This patient was of additional interest because of his family history. Specifically, his mother had had four primary malignant neoplasms, which included bilateral pheochromocytomas (age 39), solid thyroid carcinoma with amyloid stroma (age 23), and a mucin-producing breast carcinoma (age 33) (Figure 1). All of these tumors were consistent with a pluriglandular syndrome with carcinoma. Of further interest was the finding that the proband's maternal uncle had suffered a cerebral vascular accident at age 21 with residual hemiplegia of the left side. He had hypertension and diabetes mellitus by history. Similar findings of hypertension and diabetes mellitus were observed in other members of the family; and subsequent studies by other investigators showed that certain relatives in the maternal line manifested medullary thyroid carcinoma with amyloid and pheochromocytoma, with a mode of transmission in the family consistent with an autosomal dominant factor.[7]

Another remarkable family has been studied by Kontras and Newton[8] wherein three patients in two generations had histologically verified Wilms' tumor. A fourth member died in early childhood from "kidney tumor" which was not verified but was suspected of being a Wilms' tumor. Dominant inheritance with reduced penetrance was postulated to explain the genetic transmission in this family. Similarly, Wilms' tumor was recently verified in three generations in a family.[9]

In spite of reports of several remarkable families prone to Wilms' tumor, hereditary factors in this problem have not been systemically studied. Lynch and Green[6] reviewed the literature and were able to find several additional reports of families with two or more affected relatives. For example, MacKay[10] reported a family which included seven siblings, five with congenital kidney lesions, of whom two had congenital Wilms' tumors. Wilms' tumor has also been described in identical twins.[4, 5] In a family reported by Miller *et al*,[4] two brothers and a first cousin were reported to have Wilms' tumor. Findings from their series also included a child with Wilms' tumor with a sib who had a brain cyst; another proband had a sib with hemangioendothelioma of the external ear and congenital adrenal hypoplasia, while the sib of another proband was reported to have died of liver cancer at 15 years of age.

Wilms' tumor has been described in context

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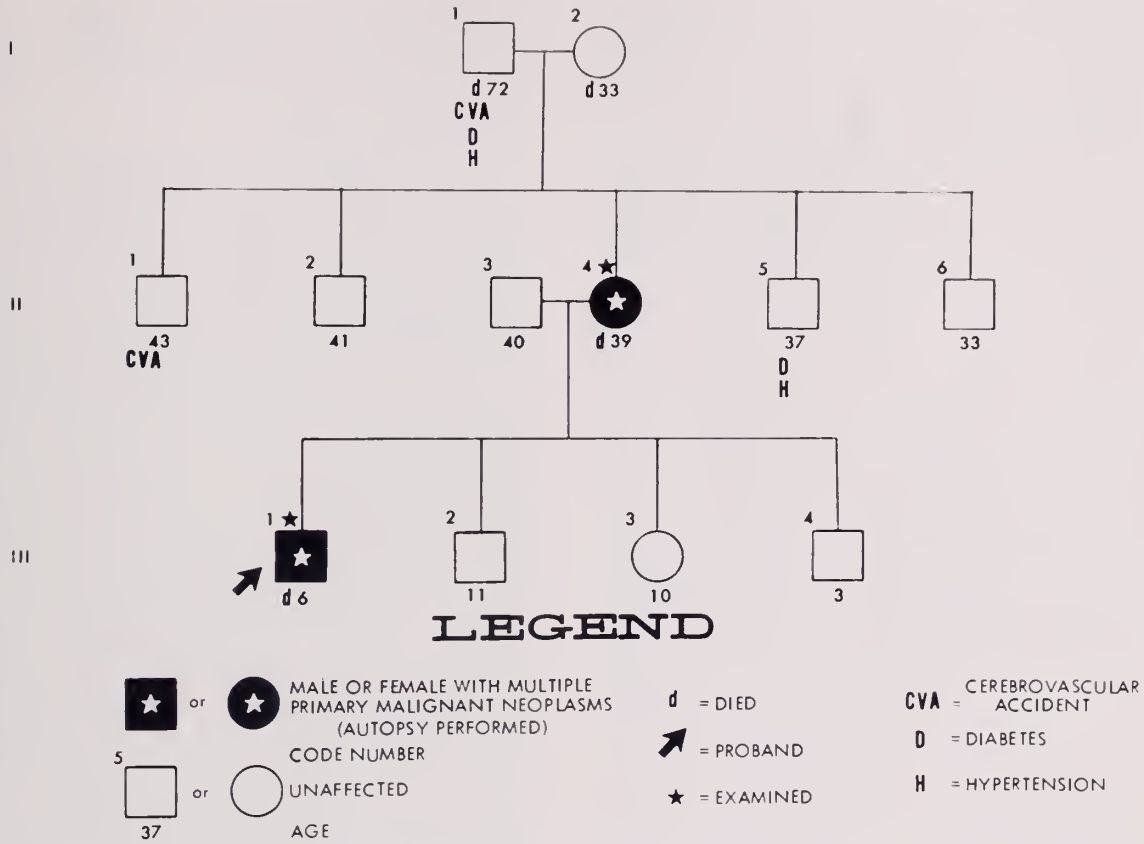

Figure 1. Pedigree of family wherein the proband (III-1) had bilateral Wilms' tumor and congenital heart disease. His mother (III-4) had four separate primary neoplasms, including bilateral phaeochromocytoma with metastases to the liver. (From Lynch and Greene [1968], Amer J Dis Child 115, 723).

with pseudohermaphroditism and chronic glomerulonephritis in a five-month-old boy with a suggestion that this might constitute a clinical syndrome.[11] This patient was said to have had the first histologically documented case of infantile glomerulonephritis associated with pseudohermaphroditism, though several instances of the combination of glomerulonephritis and pseudohermaphroditism discerned later in childhood are reported in the literature. Interestingly, in two reports of glomerulonephritis with pseudohermaphroditism,[12, 13] the tumors were derivatives of the urogenital ridge. Specifically, Drash *et al*[12] reported Wilms' tumors involving the right kidney in each patient and Frasier *et al*[13] reported on gonadoblastomas and teratoma. The review by Spear *et al*[11] contains other reports of Wilms' tumor occurring in association with pseudohermaphroditism and in the nephrotic syndrome. These authors also called attention to the frequent occurrence of gonadal tumors in hermaphrodites. Before these combinations can be considered in terms of a syndrome, serious thought should be given to their etiology with special attention to hereditary factors as well as to the action of teratogenic agents during pregnancy.

Thus, from this review of Wilms' tumor, we find a challenging field of investigation for cancer epidemiologists as well as embryologists, pediatricians, and geneticists.

Urinary Bladder Cancer

Fraumeni and Thomas[14] reported the occurrence of carcinoma of the urinary bladder in a man and his three sons. This was a white family of Russian-Jewish origin who had emigrated to the United States in 1910 and had settled in the Washington, D.C. area. There were no consanguinous marriages in the family. None of the family members had been exposed to dyes, chemicals, or occupational agents which have been either incriminated or suspected in bladder carcinogenesis. Each affected patient, however, had smoked approximately one pack-

age of cigarettes daily since adolescence, though the proband had discontinued his smoking habit 17 years prior to the diagnosis of bladder cancer.

In a single family report of this type it is not possible to define clearly the mechanism involved in the familial aggregation of cancer. The possibility of a chance event cannot be excluded, though the frequency of this site-specific malignant neoplasm in the family suggests either a common environmental exposure or a genetic effect and/or the interaction of both. With the exception of cigarette smoking, no common carcinogenic exposure was observed. However, we should note that it has been estimated that cigarette smokers have a two-fold to three-fold greater risk of developing carcinoma of the urinary bladder than do nonsmokers.[15]

The only large genetic study on the subject is that of Morganti and associates;[16] this involved a comparison of 160 patients with urinary bladder cancer with 160 age-matched healthy controls. The authors found a history of bladder cancer in four relatives of the probands in the experimental group and in two relatives of the control group, a difference which was not statistically significant.

It will be important that evidence of bladder cancer in families be meticulously documented. Such studies should include a critical evaluation of potentially significant carcinogenic exposures including habit patterns such as cigarette smoking, which may be operating in concert with host factors.

Carcinoma of the Ureter

Carcinoma of the ureter has been histologically verified in a 68-year-old white woman and in her 53-year-old son.[17] There was no evidence of tumors of the genito-urinary system in any other relatives. However, details of the search for and documentation of cancer genealogy were not presented in this study.

This is the only report of familial occurrences of carcinoma of the ureter that we have been able to locate. It is possible that this familial association is due to chance, and therefore it may not harbor any epidemiologic significance. However, carcinoma of the ureter occurs relatively infrequently in the population, and the occurrence in a mother and her son merits further careful inquiry.

Testicular Carcinoma

The genetic literature on testicular tumors reveals a paucity of familial occurrences of these lesions.[18-24] To date, five sets of twins and four sets of non-twin brothers with primary testicular tumors have been reported according to a review by Young and Bohne.[23] In addition, these authors reported the first example of non-twin siblings with histologically documented tumors of the same cell type, and in this case, seminoma. It was also of interest that two of the five pairs of twins reported in the literature have been afflicted with seminoma alone.[23]

We are aware of a family wherein a father and son both had testicular tumors. The son had a histologically verified seminoma and had undergone treatment for an undescended testicle several years prior to the occurrence of the malignant neoplasm. His father allegedly had seminoma, though histological verification of this lesion was lacking.[24]

Testicular cancer occurs in excess in the testicular feminization syndrome as described below.

Testicular Feminization Syndrome

The testicular feminization syndrome occurs infrequently but has pertinence for this discussion because of the increased risk for testicular cancer in certain members of affected families.[25-28] Patients with the syndrome have a female habitus with absence of or scanty axillary and pubic hair, female external genitalia, with variable stages of under-development of the labia with a blind ending vagina (which is usually adequate for sexual relations). These patients appear outwardly as females and they manifest the psycho-sexual orientation of the female. They frequently marry and often enjoy a normal sex life.[27-29] There is an absence of development of internal genitalia except for rudimentary uterus and for gonads (testis) which may be intra-abdominal or may be found along the course of the inguinal canal. The gonads are comprised largely of semini-

ferous tubules characterized usually by the absence of spermatogenesis but frequently with a marked increase in interstitial cells.

Karyotypes usually indicate a normal male (46XY) pattern. Genetic studies of families have shown an inheritance pattern with transmission through the maternal line,[26] consistent with inheritance by either a sex-linked recessive or male sex-limited autosomal dominant mechanism. Linkage studies for genes on the X-chromosome have not yet yielded conclusive results.[26, 30]

The relationship of this syndrome to cancer has promulgated considerable debate in the literature. For example, Morris[25] found only one patient with cancer below the age of 20 but he did find 11 cases or 22 per cent cancer frequency in patients over 30 years. Jones and Scott[31] estimate malignancies occurring in approximately five percent of such patients, while Hauser[32] estimates that about eight per cent of patients will develop cancer. However, the true incidence of cancer in patients with TFS is difficult to evaluate since many patients have been treated with prophylactic gonadectomy at an early age.

The most frequent form of cancer occurring in these patients is seminoma,[32] although other tumors including teratocarcinoma,[34] embryonal cell carcinoma,[33, 34] as well as a gonadal sarcoma in a single patient[35] have been reported.

Genetic counseling for such patients is obviously an exceedingly delicate matter. It must be approached so that no unnecessary psychiatric or emotional burden is imposed upon the patient. Thus, in the interest of the patient, as well as her husband, the physician must guard against divulging the full implication of the XY genotype.[26, 29, 35]

However, it is important that appropriate information be given concerning the cancer risk to the patient's gonads; details about the issue of gonadectomy should be given. In addition, the timing of prophylactic gonadectomy is important. While some authors have suggested the need for immediate gonadectomy, even in prepubertal patients,[36] others have been reluctant to advise prophylactic gonadectomy for any of these patients.[32]

O'Connell and associates[29] advise that bilateral gonadectomy be performed following puberty. They reported a family wherein TFS was found in three siblings, one of whom developed metastatic seminoma while a second sibling had a testicular tubular adenoma (Sertoli cell tumor). They performed prophylactic gonadectomy on two of these siblings.

In summary, we find that TFS involves a genetic defect wherein cancer of a specific type, involving the gonad, occurs in excess and wherein advice to the family in addition to genetic risk, must be tempered extremely carefully because of profound psychological and psycho-sexual implications; finally, recommendation of prophylactic gonadectomy may be of crucial importance to the patient's welfare.

Cancer of the Prostate

Cancer of the prostate is the second most common cause of death in males in the United States. Despite its frequency its epidemiology has not been investigated extensively. Wynder and associates[37] have recently studied a large number of patients with prostate cancer and compared them with a control group and, in addition, they have reviewed epidemiologic findings for this disease. In their comparison of prostate cancer patients with controls they found no differences with respect to educational level, tobacco and alcohol habits, past surgical or medical histories, circumcision, weight, height, or blood groups, Their literature review showed clinical prostatic cancer to be exceedingly rare in Japan, with an increase in its frequency among Japanese immigrants in the United States. No major environmental factors were found which could explain the possibility that prostatic cancer is hormone related. However, it was agreed that factors that might influence endocrine etiology are difficult to determine through interview methods.

Breast cancer also shows an epidemiologic pattern somewhat similar to prostate cancer, in that breast cancer occurs relatively infrequently in Japan, but increases in fre-

quency among Japanese immigrants in the United States. Another possible link to the epidemiology of cancer of the prostate and breast stem from recent observations[38] which showed a significant familial association between carcinoma of the breast and prostate. Thus, common epidemiologic factors that influence both these lesions may be manifested through interactions with familial host factors.

Cancer of the prostate has a low incidence rate among Jewish men in the United States. This may be related to the relatively low rate of prostatic cancer observed generally among imigrants from eastern Europe. However, native-born Jews appear to have rates for prostatic cancer which are similar to those of other Caucasians born in the United States.[39] Wynder believes that further elucidation of etiology for prostatic cancer may be expedited through multidisciplinary studies concentrating on the apparent differences in the incidence of prostatic cancer among native Japanese and Japanese immigrants to the United States, and among Caucasions and Negroes native to the United States.

Lynch *et al*[39] previously studied family histories of 109 consecutive patients with prostatic cancer. Only 4.5 percent of these patients had first degree relatives who manifested this disease. Due to the advanced age of the propositi, however, their family histories were often incomplete. One noteworthy feature of this survey was the observation that 20 per cent of the patients showed multiple primary malignant neoplasms, with two of them each showing five separate primary malignant neoplasms.

There has been relatively very little investigation of the hereditary aspects of prostate cancer. Two studies on the subject[40, 41] indicated approximately a three-fold increase of this lesion among fathers and brothers of affected propositi compared to controls. A major limitation of these studies, however, has been their dependency upon data derived from death certificates, which are therefore characterized by the lack of critical clinicopathologic correlation.

Conclusion

This brief survey of genetic and/or familial factors in cancers of the urological system reflects a need for systematic inquiry into the significance of host factors in these particular problems. In certain circumstances recognition of genetic etiology could harbor cancer control implications.

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Computer Assisted Analysis of Abnormal Laboratory Tests — A Report of Local Experience*

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Part II

Results

The results of the computer printouts were roughly in three categories:

First, those cases where all tests were normal for age and sex and the computer printout was a simple statement of that fact. Second, a group of cases where the admission laboratory profile abnormalities suggested one or more specific diagnoses and these were listed in the computer printout.

Third, a group of cases where no specific diagnosis or diagnoses were suggested and the computer then listed all of the diagnostic possibilities for each abnormal laboratory test.

Sometimes, these listings seemed almost endless and we had to accept numerous facetious comments in regard to the possibility of recycling the paper and the number of days it would take a physician to read all of these diagnostic possibilities on the carefully folded printout sheet on the chart.

Examples of these various reports and the format used for such reporting is given in figures 1, 2 and 3.

In regard to general categories of the

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Figure 1

COMPUTER ANALYSIS OF ABNORMAL LABORATORY TESTS
PHYSICIANS PATHOLOGY LABORATORY

MIL NORMAL RANGES ASSUME PATIENT IS FEMALE IN BED AND FASTING
DATE: 4/14 AGE 54. PATIENT NO. 7 LGH
DR. PU
All TESTS NORMAL FOR AGE AND SEX

Figure 1: Example of computer printout where chemistry profile was normal.

Figure 2

COMPUTER ANALYSIS OF ABNORMAL LABORATORY TESTS
PHYSICIANS PATHOLOGY LABORATORY

OV NORMAL RANGES ASSUME PATIENT IS FEMALE IN BED AND FASTING
DATE: 4/14 AGE 41. PATIENT NO. 45 BEATRICE MED
DR. RA

ABNORMAL TEST	VALUE	NORMAL RANGE	STD. DEV. AWAY FROM NORMAL
GLUCOSE	226.000	67.000 - 122.000	8
BUN	22.000	4.200 - 21.700	1

POSSIBILITIES
DIABETES MELLITUS

(Figure 2 continued)

COMPUTER ANALYSIS OF ABNORMAL LABORATORY TESTS
PHYSICIANS PATHOLOGY LABORATORY

ZI NORMAL RANGES ASSUME PATIENT IS FEMALE IN BED AND FASTING
DATE: 4/14 AGE 59. PATIENT NO. 34 BMH
DR. MO

ABNORMAL TEST	VALUE	NORMAL RANGE	STD. DEV. AWAY FROM NORMAL
BILIRUBIN	8.200	0.200 - 1.100	32
ALK. PHOS.	271.000	17.000 - 92.000	10
LDH	514.000	77.000 - 212.000	9
GLUCOSE	199.000	69.000- 126.000	6

POSSIBILITIES
METASTATIC TUMOR IN LIVER

Figure 2: Examples of computer printouts where abnormal tests suggested specific diagnoses. Note list of abnormal tests, values obtained, normal range and standard deviations from normal.

Figure 3

COMPUTER ANALYSIS OF ABNORMAL LABORATORY TESTS
PHYSICIANS PATHOLOGY LABORATORY

NORMAL RANGES ASSUME PATIENT IS MALE IN BED AND FASTING
DATE: 4/14 AGE 50. PATIENT NO. 23 BMH
DR. ST

ABNORMAL TEST	VALUE	NORMAL RANGE	STD. DEV. AWAY FROM NORMAL
CHOLESTEROL	326.000	121.000 - 272.000	2
TOTAL PROTEIN	8.100	5.700 - 8.000	1

POSSIBILITIES
NO SPECIFIC DIAGNOSIS SUGGESTED — DISEASES RELATED
TO ABOVE ABNORMAL TESTS FOLLOW:

HIGH CHOLESTEROL
DIAGNOSTIC POSSIBILITIES
PRIMARY (FAMILIAL) HYPERCHOLESTEROLEMIA
HYPERLIPOPROTEINEMIA'S
DIABETES MELLITUS
NORMAL PREGNANCY (IF FEMALE)
NEPHROTIC SYNDROME
HYPOTHYROIDISM
HYPOPHYSECTOMY
PANCREATITIS
HEPATIC DISEASE
AFTER ACUTE HEMORRHAGE
CORTISONE THERAPY (ABOUT 20 PCT RISE)
PRIMARY ESSENTIAL XANTHOMATOSIS

HIGH TOTAL PROTEIN
DIAGNOSTIC POSSIBILITIES
DEHYDRATION
CHRONIC LIVER DISEASE
NEOPLASMS, ESPECIALLY MYELOMA
DYSPROTEINEMIA (MACROGLOBULINEMIA)
COLLAGEN DISEASE, PARTICULARLY LUPUS AND ESPECIALLY LUPOID HEPATITIS
GRANULOMATOUS DISEASES, INCLUDING SARCOIDOSIS
CHRONIC ALCOHOLISM (ABOUT 10 PCT OF ALCOHOLICS, SGOT USUALLY HIGH TOO)
BACTERIAL PNEUMONIA
SUBACUTE BACTERIAL ENDOCARDITIS
TUBERCULOSIS
LEUKEMIA
RHEUMATIC FEVER
TROPICAL DISEASE (SCHISTOSOMIASIS, LEPROSY)
VENOUS STASIS DURING VENIPUNCTURE

Figure 3: Example of computer printout where no specific diagnoses were suggested and computer lists all possible causes for each abnormal test.

printouts, Table 1 shows that of 757 printouts, 261 fell into the category of all tests normal for age and sex; 268 listed specific diagnostic possibilities suggested by the abnormal profile results and 228 were cases in which only a list of individual abnormal lab tests and associated possibilities was made and no specific diagnoses were printed by the computer.

Evaluation

After completion of the project, we tried to evaluate the results in two major ways. *First*, by a brief questionnaire to the physicians of the medical staff and *second*, by reviewing the charts of the patients discharged after having had computer analysis performed and seeing whether the computer printout results were used by the physician or included in final diagnosis.

The results of the questionnaire replies sent to staff physicians is given in Table 2. Of the 60 physician questionnaires returned, 8 physicians said it was never helpful to them; 30 said it was occasionally helpful and 22 said it was frequently helpful. Another question concerned the matter of whether they anticipated that they would order the computer printout, if it was made available for a nominal charge. Fourteen of the 60 physicians said they would rarely order it, 30 said they would order it occasionally, and 16 said they would order it frequently.

In our postdismissal chart review we found that when a specific diagnosis or diagnoses were suggested by the computer, one or more of these diagnoses was also listed in the final diagnosis by the attending physician 50% of the time. Of the group where all tests were normal for age and sex, 90% were admissions for elective surgery or for psychiatric related conditions.

Table 1
COMPUTER ANALYSIS
GENERAL CATEGORIES OF PRINTOUTS

All tests normal for age and sex	261
Specific diagnosis or diagnoses made	268
Insufficient data for diagnosis — abnormal tests listed with possibilities for each	228
	757

Table II
COMPUTER ANALYSIS EVALUATION OF PROJECT

Cards sent to staff physicians	75
Cards returned by staff physicians	60
Helpful?	
Never	8
Occasionally	30
Frequently	22
Anticipate Ordering?	
Rarely	14
Occasionally	30
Frequently	16

Summary and Conclusions

We found that this type of simple computer analysis of a limited group of laboratory tests which were performed on all adult admissions to a hospital was possible, and although some problems were encountered, the project went quite smoothly. We found that it was generally well accepted by physicians on the medical staff but were surprised when subsequent followup showed that although nearly 70% of the physicians indicated on questionnaire that they would anticipate ordering the printout occasionally or frequently, actually there were very few orders when it was no longer part of the routine admission procedure. This was probably as much related to our failure to develop a mechanism for easy ordering as it was to a lack of interest in the computer printout or lack of confidence in its results.

Subsequent refinements in the computer program, made after the project was terminated, suggest that more specific diagnoses and fewer long printouts can be achieved.

We also learned that the cost factor can be kept to a minimum.

A major problem was in transporting the results of the SMA 12/60 tests to the computer center, returning the printouts to the hospital, and placing them on the chart. Nevertheless, this was not an insurmountable obstacle, and most of the time the printout results were on the hospital record within 24 hours of the time the profile test results were charted.

We learned that even though we were restricting our computer project to a group of 12 commonly performed admission laboratory tests rather than all laboratory procedures, many of the specific diagnoses suggested by the computer were actually found to be listed in the physician's final diagnosis when the completed chart was reviewed.

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Familiar Susceptibility to Anesthesia

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Abstract

A white male, 38 years old, in apparently good health, underwent hemorrhoidectomy, and was apneic and unconscious 4½ hours after general anesthesia.

He made a good recovery following resuscitative measures described here. He had been extremely sensitive to smoking and to aspirin.

A brother and a sister both exhibited a similar untoward reaction to general anesthesia. There may be a family history of seizures.

THIS is the first reported case of an unusual reaction to anesthesia involving a family, possibly related to seizures and to elevated erythrocyte and lymphocyte levels.

This is an account of a patient who underwent hemorroidectomy one morning. The operation began at 10:30 a.m. and was over at 11:05 a.m. I did not administer the anesthetic, but was called to another hospital to see him at 3:00 p.m. He was not waking; his respirations had become shallow, and soon stopped.

Preanesthetic medication consisted of morphine sulfate 16 mg, and scopolamine 0.4 mg. He was given 36 ml of 2.5 percent thiopental, 3 ml of curare, and a nitrous oxide-oxygen mixture.

I was assured that the anesthetic was properly given; other pieces of the puzzle were later to come to my hand. He was 38, white, married, childless, and unemployed. He was a large man, but not muscular. His heart and lungs were considered to be normal. RBC was 6,150,000; WBC 8,150, lymphocytes 49 percent.

Between 11:15 a.m. and 2:30 p.m., he received pentylenetetrazol 2 ml IV, nikethamide 1.5 ml IV, pentylenetetrazol 1 ml IV, pentylenetetrazol 2 ml IV, neostigmine 1:4000 (dose not stated), picrotoxin 3 mg IV, and pentylenetetrazol 1 ml IV.

I performed tracheal intubation at 3:10 p.m. and administered artificial respiration easily. I injected human serum albumin intravenously for possible cerebral edema. He moved about at 5:30 p.m., responded to sound and touch at 6:30 p.m., and was talking by 8:30 p.m.

The systolic blood pressure rose from 128 to 156 mm Hg during surgery, it fell to the eighties at 7:40 p.m., was in the nineties at 8:45 p.m., and rose above 100 at 5:30 a.m. He then proceeded to make a good recovery.

He had headache for three days after the operation, he experienced diplopia and strabismus, he said later, and some difficulty in far and possibly in near vision. He had shown, before the operation, extreme sensi-

tivity (he would perspire) to smoking, and to half an aspirin tablet. He had been a stutterer; his eyes, he said, had always been "stationary."

His mother died at 49, after having been sick all her life. She had a spinal injury at about 15, and began to develop seizures some five years later.

He has two brothers and one sister. Both brothers stutter. One of them underwent dental extraction under thiopental anesthesia seven years before and was disoriented for ten days. He developed severe headaches afterward. He suffers from duodenal ulcers. He also experiences episodes of nausea, visual aura, and loss of muscle control. He may have been given shock therapy.

The sister was operated on approximately five years before, probably for ovarian cyst, and was given oxygen for three days after. She has some kind of trouble with her eyes ("stationary").

No member of the family to whom I spoke seemed aware of the possibility of epilepsy.

This is the first case of which I am aware of an unusual reaction to general anesthesia involving a family, possibly related to seizures and to stammering, and associated with elevated erythrocyte and lymphocyte counts.

Primary Carcinoma of the Duodenum With a Recent Case History Of a Two Year Survival

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and

STEVEN F. WEBSTER, M.D.**

IN reviewing the recent literature on primary carcinoma of the duodenum, it becomes evident that this disease entity is a rare one and also that the survival rate following surgical treatment is not an encouraging one.

Gastrointestinal carcinoma with the primary site in the duodenum was first documented by Hamburger in 1746.[12] Since that time there has been a considerable amount of literature written on the subject. The case to be presented describes a patient with primary carcinoma of the duodenum who underwent a Whipple procedure and has been followed postoperatively with chemotherapy. The patient was alive and felt well over two years postoperatively.

A 59 year-old, white male presented with the chief complaint of right upper quadrant and epigastric pain and tenderness. The patient stated that he had been aware of the symptoms for the past several years with the onset of right upper quadrant pain in 1958. In 1958, an oral cholecystogram was reported as normal, but the patient was still placed on a low fat diet. He stated that he would remain asymptomatic as long as he stayed within the bounds of his diet. Eating of fatty foods would result in right upper quadrant pain and nausea.

Approximately two weeks prior to his hospitalization in July, 1971, the patient had a followup oral cholecystogram which revealed a non-functioning gallbladder. This was repeated with the same findings and it was felt at that

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time that the patient did in fact have gallbladder disease. Upon hospitalization, the patient denied any previous history of hepatic disorder, jaundice, or right upper arm pain referred to the right shoulder. The patient did report epigastric burning and tenderness. Also, he reported that he had noticed regurgitation of food and gastric contents when in the supine position following meals. He stated that the burning was often relieved by an antiacid preparation and that with the head of his bed elevated he could avoid the regurgitation. The patient denied any history of hematemesis, melena, clay white colored stools, or diabetes mellitus. He stated that otherwise he felt he was in good health.

Physical examination showed a well developed, well nourished, male in no acute distress. There was moderate tenderness noted on palpation of the epigastric region. There were no evident masses in the abdomen and bowel sounds were normoactive. The rest of the physical examination was essentially within normal limits and the diagnostic impression was chronic cholecystitis and a hiatus hernia with reflux esophagitis.

The laboratory work was essentially within normal limits except for an elevated sedimentation rate of 24 mm/hour, a mildly elevated serum amylase of 178 units and a fasting blood sugar of 140.

The gastrointestinal x-rays revealed spasm or extrinsic compression on the second portion of the duodenum and a rather massive gastrectasis which was suggestive of gastric outlet obstruction in the pyloric canal or duodenum.

Laparotomy followed on July 21, 1971, with a preoperative diagnosis of chronic cholecystitis and stenosing duodenal ulcer. The gallbladder was found to be extremely distended and to contain stones. There was an indurated mass in the head of the pancreas encroaching on the second portion of the duodenum. The esophageal hiatus admitted two fingers. The gallbladder was removed. A small wedge biopsy was taken from the tumor tissue for frozen section which was reported as adenocarcinoma of questionable gastrointestinal origin. It was found that the tumor mass was adherent to the anterior wall of the inferior vena cava. A Satinsky clamp was placed on the inferior vena cava beneath the point of infiltration and the anterior wall which was infiltrated by the tumor was excised along with the entire duodenum and the distal 50 percent of the stomach. This was removed en bloc and an end-to-end choledochojejunostomy and end-to-side pancreaticojejunostomy was then performed. Next, an end-to-side gastrojejunostomy was accomplished. The abdomen was closed and the patient withstood the procedure well, receiving five units of blood during the operation. The postoperative diagnosis was chronic calculus cholecystitis and adenocarcinoma of the head of the pancreas.

The subsequent pathologic report from excised tissues came back as mucin secreting adenocarcinoma arising in the duodenal mucosa. (Figure 1) The gastric and peripancreatic lymph nodes were reported as reactive hyperplasia. Carcinoma was also present in the fat surrounding the margins of excision of the common bile duct. The patient was dismissed from the hospital doing well approximately 10 days postoperatively.

The patient was re-admitted to the hospital two weeks following dismissal with possible gastrojejunal obstruction. The x-rays revealed only an acute gastritis and he was discharged on a bland diet much improved.

In January, 1972, the patient was admitted for followup and a complaint of low back pain. The subsequent workup revealed no evidence of recurrent tumor and the patient was discharged to be followed in the office. (Figure 2)

In April, 1972, a large liver was noted, possibly due to liver metastases, and 5-fluorouracil treatments were ini-

tiated. 5-fluorouracil 500 mgm. was given intravenously weekly. Methotrexate given orally was added to the regime in July, 1973, when a mass was noted in the epigastrium.

Two weeks following the addition of the methotrexate the patient was hospitalized complaining of severe abdominal pain. The complete workup that followed revealed a palpable mass in the epigastrium and evidence of neoplastic infiltration of the distal ileum and adjacent transverse colon but no evidence of any bowel obstruction. A diagnosis of abdominal carcinomatosis and chemical enteritis secondary to the methotrexate was made. The methotrexate therapy was discontinued. The patient improved rapidly and was dismissed to be followed in the office with regular 5-FU treatments.

Incidence

The incidence reported throughout the literature for primary carcinoma of the duo-

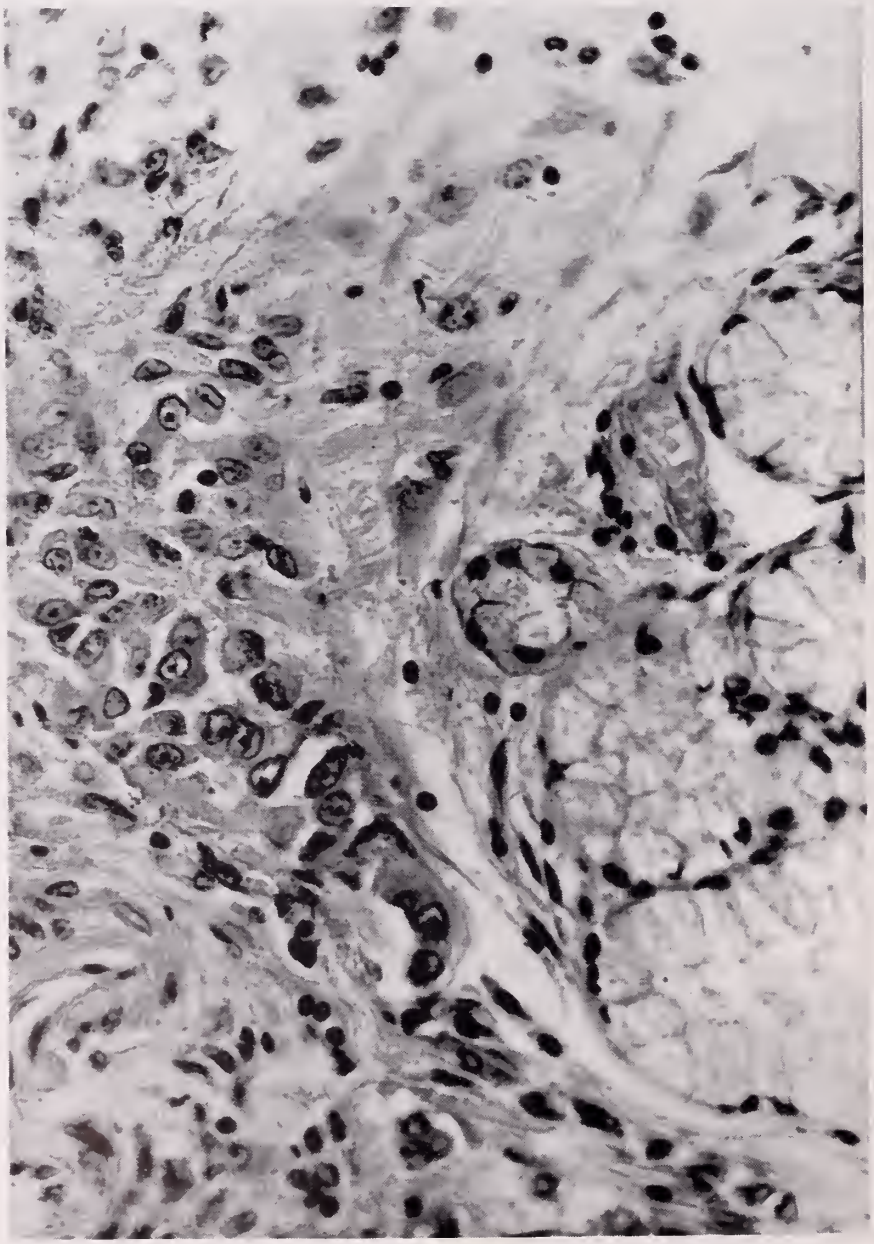

Figure 1
Microscopic Section of Tumor

denum is exceedingly rare. Reports vary from paper to paper but generally autopsy figures for carcinoma of the duodenum range from 0.019% to 0.5%.[3, 4] When speaking only of the gastrointestinal tract, incidences of 0.35% to 3.1% have been reported. More specifically regarding the incidence within the small intestine, this neoplasm occurs most commonly in the duodenal portion. Figures for the small intestine indicate that 33% to 45.6% of neoplasms originate in the duodenum.[1, 4, 9, 12] Within the duodenum itself, the most common location for carcinoma is the second or periampullary portion with the third or infra-ampulla having the lowest incidence.[4, 7, 9, 12]

The disease seems to predominate in late middle aged males. Ages ranged from 35 to 75 years with the mean age varying from 53 to 62.7 years.[2, 5, 8, 12] The disease is encountered in males over females 3:1.[9, 10] Also, Caucasians seem to have a higher incidence of this disease, as reported by Cortese.[4]

Pathology

By far the majority of malignancies of the duodenum are adenocarcinoma. Sarcomas and benign tumors are uncommon; however, they have been reported along with the malignant carcinoid and lymphomas.[5, 6, 12] Blumgart and Kennedy[2] classify adenocarcinoma of the duodenum into two types. Type I is described as papillary masses which extend into the lumen of the duodenum. The second type, or Type II, would best classify our tumor. Type II was described as consisting of ulcerating or stenosing growths which were non-papillary, produced mucin and had a scirrhous stroma.

Staging of these tumors are best described by Hans Dencker.[5] He assigns four stages to periampullary tumors. Stage one includes tumors confined to the organ of origin. Stage two includes those with slight extension, but no metastatic lymph node involvement. Stage three includes the tumors with regional node involvement and stage four involves widespread extension with residual local tumor tissue and/or remote metastases outside of the resected area. The case presented here would fall into Dencker's second stage as would 50% of the cases that he studied.

Metastatic spread involves regional lymph nodes, pancreatic and gastric nodes and on to the hepatic chain. Less frequent spread is to the superior mesenteric chain.[9] The majority of meastases are to the liver and pancreas.[12]

Diagnosis

The diagnosis of carcinoma of the duodenum is a difficult one to make. Due to the

Figure 2
Liver Scan

symptomatology resembling various other disease entities, it is often misdiagnosed.

The initial step in diagnosis of this diseases is, of course, the history and physical. The early symptoms are usually vague and are most commonly epigastric pain and loss of weight. Anorexia and vomiting are also common symptoms.[1, 2]

The pain associated with duodenal malignancy is often described as dull and constant. It may be localized in the epigastrium, the periumbilical region, the right upper quadrant, the left upper quadrant, the left lower quadrant, or it may even radiate to the back. The radiation pain to the back is more frequent in those patients with involvement of their pancreas. The pain is seldom relieved by foods or antiacids.[4, 7, 12] Additional symptoms described include gastric stenosis, bloating, hematemesis, weakness, fatigue, fever, chills, diarrhea, constipation, puritis and hemorrhage from mild to severe.[4, 7, 12] The average length of history of symptoms ranged from 6.7 weeks in one study to 11 months in another.[2, 12]

Later symptoms relate to the growth characteristic and location of the tumor mass. Obstructive lesions produce anorexia, vomiting, postprandial epigastric fullness and gastric dilatation. Ulcerating lesions produce weakness, fatigue, and hemorrhage. Bile obstruction and jaundice occur most frequently with tumors of the periampullary region with extension into the bile ducts or pancreas.[4, 9]

The physical examination may be unremarkable or may reveal icterus, varying degrees of abdominal tenderness, hepatomegaly or a palpable mass.[10, 12]

The next tool in the diagnostic plan, however of limited value, is the laboratory. Various abnormal laboratory values have been reported as associated with carcinoma of the duodenum. The most common of these were an elevated erythrocyte sedimentation rate, iron deficiency anemia, and positive fecal occult blood tests.[2, 12] Other abnormal studies included hyperbilirubinemia, elevated serum transaminase levels, and cytological examination of duodenal contents.[4, 10, 12]

To date, the x-ray seems to be the most reliable diagnostic tool short of actual biopsy.[4, 12] The Roentgen abnormalities associated with this disease include constriction with or without dilation of the proximal duodenum and stomach, rigidity of the duodenum, thickening or ulceration of the mucosa, and irregular polypoid filling defects.[4, 12]

A more recent diagnostic tool which may prove to be of some value is the use of fiberoptic duodenoscopy with endoscopic pancreatocholedochography and biopsy.[2] Preoperative biopsy, due to its high diagnostic accuracy, is recommended by Dencker before proceeding with the surgical correction.[6]

Treatment

Radical surgery in combination with early diagnosis remains the only possible hope of curing this disease. The pancreaticoduodenectomy is the operation of choice in resectable lesions.[1, 5, 10, 13] Guidelines for tumor resectability as set up by Lansing are as follows: first there is no evidence of distant metastases; second, the lymph nodes involved appear to be localized to the immediate area; and thirdly, the extent of local invasion into the portal or mesenteric vessels does not prevent mobilization of the tumor.[10]

The use of radiation and/or chemotherapy has received some support.[1, 4] Chemotherapy as an adjunct to radical surgery may hold some promise as seen with the case presented.

Survival

Survival rates are dependent upon both the extent of tumor involvement and postoperative status including the management and complications.

The most persistent causes of postoperative death are sepsis related to leakage at the anastomosis and/or hemorrhage. Other common causes of postoperative morbidity and mortality include intestinal obstruction, pancreatic fistula formation, thrombo-embolism, pneumonia, and portal vein thrombosis.[5, 8, 10] Recent figures on postoperative mortality rates range from 25% to 36.4%.[2, 5, 12]

Long-term survival rates must be considered. As is generally accepted, all malig-

nancies of the gastrointestinal tract carry with them a rather poor prognosis. In reviewing the recent literature on patients undergoing pancreaticoduodenectomy for carcinoma of the duodenum, the survival rates reflect as previously a discouraging prognosis.

In Dencker's recent study, five of the six patients diagnosed as having carcinoma of the duodenum died of metastases within two years following surgery. The remaining patient was alive five years postoperatively with a leiomyosarcoma.[5]

Cortese and Cornell report a crude five year survival rate of 28% of those fourteen patients subjected to surgery for carcinoma of the duodenum.[4]

In a study by Blumgart and Kennedy, eleven patients with tumors of the same type as the one we have reported underwent pancreaticoduodenectomy. A hospital mortality of 36.4%, a two year surgical rate of 36.4%, and a five year survival rate of 9.1% were reported.[2]

Summary and Conclusions

This presentation adds another case to the literature of primary carcinoma of the duodenum. The case was reported because of the long survival and also its uniqueness in that the patient has been managed postoperatively with chemotherapy.

Although carcinoma of the duodenum is an exceedingly rare disease entity, it carries with it a poor prognosis whenever it does occur. At present, radiography remains as the best diagnostic tool. New technics in diagnosis, for example, fiberoptic duodenoscopy and laparoscopy are being examined.

In spite of poor survival rates reported, radical surgery is presently the accepted treatment. The case reported here gives some support to the addition of chemotherapy postoperatively in an attempt at improving survival rates. It also seems that careful attention to surgical technics with intensive postoperative followup would reduce morbidity and mortality.[11]

Addendum

During the months of writing this paper, the patient developed a partial small bowel obstruction in December, 1973. At the time of surgery, huge dilated loops of small bowel were found as well as numerous implants of tumor tissue along the mesenteric margins of the bowel producing the partial small bowel obstruction. There was a large adherent mass in the right upper quadrant of the abdomen with a tremendously distended cecum and appendix. There was evident obstruction in the hepatic flexure of the colon. The sigmoid colon was essentially normal in size and appearance although there was some edema as would be expected with the entire abdominal carcinomatosis picture.

Accordingly, reduction of the internal small bowel hernia, release of adhesions and a mushroom tube cecostomy were accomplished. He was transferred to ICU immediately postoperatively and expired on 12-9-73.

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Experience with Throat Culture and Sequential Antibody Titers: Monitoring Of Antibodies to Exoenzymes of Group A Streptococcus in the Diagnosis and Treatment of Acute Pharyngitis

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THE newly available Streptozyme 2 Minute Slide Test (STZ) detects antibodies to the streptococcal exoenzymes-streptolysin 0, streptokinase, hyaluronidase, DN-ase, and NAD-ase. The STZ reagent is a standardized suspension of aldeyhyde-fixed sheep red cells sensitized with the above streptococcal exoenzymes and is stable for one year at refrigerator temperature. Elevated serum cholesterol, bilirubin, or contamination of the serum with hemolytic bacteria have no significant effect on the test results as can occur with the conventional procedure for antistreptolysin 0 (ASO) titer determination of Rantz and Randall.[1] The STZ test is a simple slide hemagglutination of the sensitized cells with serial dilutions of the patients' serum. A rising STZ titer is indicative of recent streptococcal infection but an elevated single level is helpful in cases suspected of secondary complications with streptococci, i.e., acute rheumatic fever or acute glomerulonephritis. As with ASO titers, single STZ titers to be significant vary with geographical location. Significant ASO titers are given as 150 to 300 Todd Units depending on location. A significant ASO titer (over 166) is said to be equivalent to a STZ level of 1:100 or higher.[2, 3]

Only 80 to 85% of clinically established cases of acute rheumatic fever are associated with significant (for a particular geographical area) ASO titers. The STZ test has correlated well with ASO titers of significance in other series of streptococcal sequalae arising from streptococcal pharyngitis.[2, 3]

Association of acute glomerulonephritis cases with significant ASO titers is lower than that of acute rheumatic fever. Ofek[4] found a 95% correlation with the STZ test as compared with the ASO, suggesting that significant antibodies developing in post streptococcal glomerulonephritis were other than ASO and that the STZ titer was more useful in establishing the diagnosis of that disease.

When the STZ test was compared individually to ASO, ADNase-B and AH by Klein and Jones,[5] it was found to detect more cases with elevated titers than any of the above tests individually. They concluded the STZ test was a worthwhile screening test for laboratories (which now use only ASO for detecting recent streptococcal infection) on sera with low ASO to determine the presence of antibodies to the other exoenzymes. Ofek[4] in a similar comparative study believed that the STZ test was more sensitive and no less specific than any of the individual tests (ASO, AH and ANADG) and revealed the rise of the antistreptococcal antibodies earlier.

MATERIALS AND METHODS

The present 2 year study presents the pattern of STZ titers in patients seen for clinical pharyngitis in Auburn, Nebraska, an agricultural and small industrial community of 3400 persons in southeast Nebraska. On the first visit for the chief complaint of sore throat, a swab was taken, plated on sheep

blood agar and incubated overnight. In addition, a blood sample was obtained for the STZ test. The next morning any white, colorless or gray B-hemolytic colonies were subcultured and a bacitracin disc was placed on the streaked area. Inhibition of growth by the bacitracin was used as the criterion for treatment of streptococcal pharyngitis. All patients with positive throat cultures were treated for 10 days with oral penicillin or erythromycin in a dose of 125 mg q.i.d. below age 5 years and 250 mg if over 5 years. Subsequently blood was drawn for STZ titering at 10 and 30 days and with some repeated at 60 and 90 days. The dilutions used were 1:100, 1:150, then in increments of 100 to 1:800. The throat culture was also repeated on the 10th day. The first phase of the study was done in the winter of 1971-1972 and included 15 cases with positive cultures and 7 cases with negative cultures; a total of 39 cultures were done. The second phase was done in the same months of 1972-1973 and included 20 positive cases, 5 negative cases; a total of 127 cultures were done in this phase. A control group of patients without a history of respiratory disease in the preceding two months was included in Phase II.*

RESULTS AND DISCUSSION

Group 1 includes 5 patients with positive throat cultures and initially high STZ titers. Subsequent serial titering on these patients showed no further elevation of antibody level in response to Group A streptococcus found in their throats. These patients represent a group with non-streptococcal pharyngitis who were in a convalescent carrier state from previous streptococcal infection. Although Group A streptococci resided in the pharynx, it probably was not the infecting organism since the serial antibody titer failed to rise. Wannamaker[7] and Kaplan[8] in their series found about half of their clinical pharyngitis patients with positive Group A streptococcus cultures had no increase in antibody response. They also noted that those showing little or no antibody response carried high initial titers similar to those of our Group I. Wannamaker[7] considered such patients not to be at risk of developing streptococcal, non suppurative complications. This pattern might also be explained by an anamnestic response to a fresh case of Group A streptococcal infection or by the initial visit coming late in the course of the disease.

Group II shows that 9 patients had positive throat cultures followed by an antibody rise with failure to decline by 30 days. The last 3 patients in Group II demonstrated progressively rising STZ titers. With negative throat cultures at 10 days this probably does not indicate persisting infection but an accentuated antibody response to their initial infection as a variant of normal. The continuing rise and high titers have been considered by some to be correlated with an increased chance of developing rheumatic fever.[10] In two of these cases the STZ titer was not elevated at the first visit but rose at 10 days and in one at 30 days. This suggests that these patients came in early in the course of the pharyngitis. Antibodies to streptococci once elevated, may persist indefinitely. Significant levels may persist up to 5 years, especially if the patient is exposed occasionally to streptococci.[9]

Group III patients demonstrated an antibody rise consistent with acute streptococcal pharyngitis. The rise and subsequent fall in titer suggests response to therapy or spontaneous cure. These patients if untreated are also at risk of developing the non suppurative complications of streptococcal disease.[7]

Group IV shows patients with either throat cultures and negative STZ titers at 10 and 30 days, or basal positive titers (1:100 in phase II) with no subsequent change indicating either a false negative STZ test or a carrier state without high antistreptococcal antibody titers. Thus, 8 of the 35 patients with positive throat cultures in the total study had negative serial STZ titers (25%). The figure correlates well with the negative serial ASO titers found by others after streptococcal pharyngitis as when it is followed by rheumatic fever.[2, 3]

Group V: 6 patients with pharyngitis

*The STZ Reagent used in this study was provided by Wampole Laboratories.

but negative throat cultures had serial STZ titers performed which showed rising titers, suggestive of acute infection. Morgileth et al[11] in a pediatric streptococcus study found that repeated throat cultures after 1 to 15 minutes and including a nasopharyngeal culture increased his streptococcus detection rate by 19%. The single throat cultures in our study may have missed some streptococci.

Morgileth et al[11] also noted a significant antibody response in 21% of his patients that had a non-streptococcal pharyngitis and suggested that the possible cause for the lack of correlation between ASO and type-specific antibody response was related to the minimal stimulus required for raising the ASO titer.

Kholy et al[12] attributed the rising ASO titers in his patients with negative throat

Table 1

SERIAL STREPTOZYME TITERS OF PHARYNGITIS PATIENTS

Patient	Study Phase	Initial T.C.*	Initial Titer	10 Day	10 Day T.C.*	30 Day	60 Day	90 Day
GROUP I								
1	I	+	1:500	1:300	—	1:100		
2	I	+	1:300	1:200	—	1:150		
3	II	+	1:800	1:600	—	1:800		
4	II	+	1:300	1:150	—	1:150		
5	II	+	1:300	1:300	—	1:200	1:200	
GROUP II								
6	I	+	1:100	1:300	—	1:300		
7	I	+	1:150	1:300	—	1:300		
8	I	+	Neg.	1:200	—	1:200		
9	I	+	Neg.	1:200	—	1:200		
10	I	+	Neg.	1:150	+	1:150		
11	I	+	1:200	1:200	—	1:400	1:400	1:200
12	II	+	1:200	1:300	—	1:600		
13	II	+	1:100	1:300	—	1:400	1:500	1:700
14	I	+	1:150			1:300		
GROUP III								
15	I	+	Neg.	1:100	—	Neg.		
16	I	+	Neg.	1:100	—	Neg.		
17	I	+	Neg.	1:100	—	Neg.		
18	I	+	Neg.	1:150	—	1:100		
19	I	+	Neg.	1:100	—	Neg.		
20	II	+	1:200	1:400	—	1:300	1:300	1:200
21	II	+	1:100	1:150	—	1:150		
22	II	+	1:150	1:200	—	1:300	1:150	
23	II	+	1:150	1:200	—	1:150		
24	II	+	1:150	1:300	—			
25	II	+	1:100	1:300	—	1:100		
26	II	+	1:100	1:300	—			
27	II	+	1:150	1:300	—			
GROUP IV								
28	I	+	Neg.	Neg.	—	Neg.		
29	I	+	Neg.	Neg.	—	Neg.		
30	II	+	1:100	1:100	—	1:100		
31	II	+	1:100	1:100	—	1:100		
32	II	+	1:100	1:100	—	1:100		
33	II	+	1:100	1:100	—	1:100		
34	II	+	1:100	1:100	—	1:100		
35	II	+	1:100	1:100	—	1:100		
GROUP V								
36	I	—	1:200	1:300		1:100		
37	I	—	Neg.	1:100		1:100		
38	I	—	1:200	1:300		Neg.		
39	II	—	1:150	1:300		1:200	1:100	
40	II	—	1:100	1:200		1:150		
41	II	—	1:100	1:400		1:700	1:800	1:700
GROUP VI								
42	I	—	1:100	1:100		1:100		
43	I	—	1:800	1:800		1:800		
44	I	—	1:800	1:800		1:800		
45	I	—	1:400	1:200		1:200		
46	I	—	1:300	1:300		1:300		

*—Throat Cultures

cultures to the presence of Group C and D beta streptococcus in 11 of 36 such cases. He also suggested streptococcal infection in other areas, as skin, as possible cause for the rise.

Group VI: Five patients had a negative throat culture but high initial STZ levels which persisted unchanged indicating no recent infection but merely a high antibody level from some previous infection.

Group VII: During phase I of the study many initial titers were negative, but in phase II none were below 1:100. In phase II a control group of 26 persons without a history of upper respiratory infection for at least two months were chosen to assess the community STZ level. Nineteen (73%) had titers of 1:100, 5 (19%) had titers of 1:200 and 2 (8%) had titers of 1:300. All control patients with STZ titers over 1:100 demonstrated falling titers at 30 days indicating resolving but clinically unrecognized infection.

Klein et al[13] found in his study of "upper limits of normal" or significant ASO and ADNase-B titers that these vary with age as well as with season and geographic location. Our findings may indicate a varying base line of community antibody STZ level from year to year. From June 1971 to June 1972, 1480 throats were cultured of which 232 were positive for Group A beta hemolytic streptococcus or about 16%. From June 1972 to June 1973, 950 throats were cultured with only 89 showing Group A streptococcus or about 9%. The apparent decrease in incidence of streptococcal pharyngitis during the second year seems to conflict with the apparent rise of base line of STZ levels in apparently normal members of the community. However, these may be related to the high incidence of the year before.

Summary

In a series of patients complaining of sore throat, throat cultures were prepared and Streptozyme (STZ) titers were performed. This was repeated at the end of 10 and 30 days. Where indicated, further titrations were performed at 60 and 90 days. In 35 patients the initial throat culture was positive. Twenty five of these (71%) had STZ titers > 1:100 and 10 (29%) were STZ negative (<1:00), indicating a high diagnostic correlation between the positive plate and the positive STZ test. This confidence in the STZ test can be expected relatively early during the infection (after 6-9 days), as was also shown by Ofek et al.[6] In 6 patients with negative throat cultures, 5 (83%) had elevated STZ titers (1:100). Since these titers either fell or rose at subsequent visits (10, 30 days), it appeared that the plates were falsely negative. Total reliance on the single culture plate appears not to be justified. We now are taking two throat swabs on the same visit to decrease the chance for false negative cultures. Further, titering only at the initial office visit is of less value than repeated titering over a period of several weeks. Since the STZ test is rapid and easily performed, it is a practical means for monitoring the antibodies to the exoenzymes of streptococcus A to determine the status of the infection. Although antibodies to streptococcal antigens offer the most accurate approach to diagnosis of streptococcal infection, they are helpful only retrospectively and may be influenced by such factors as antibiotic therapy and the site of infection.[14]

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Address to Woman's Auxiliary, NMA Spring 1974

MRS. HOWARD LILJESTRAND
President-Elect, AMA Woman's Auxiliary

ABOUT a month ago, I was taking a bus from St. Louis to visit my sister in central Missouri.

I barely got started reading, when the bus driver started a chit chat that continued all the way across Missouri.

I would like to tell you about this conversation, because his lopsided views are those of laymen with a lot of votes.

I won't bother you with much of the conversation. It took four hours; but eventually he got on the subject of comparative incomes and rising costs of living; and of course you know what happened next. He started on the medical profession, stating that the doctors were the very worst.

He surprised me by saying that plumbers and electricians should be paid the same amount as doctors. He thought that a plumber who installs a pipe to provide water to the doctor's office is just as important as the doctor, and should be paid just as much.

He added that plumbers and electricians spend several years in apprenticeship training just like a doctor. I suddenly realized that in his mind a four year apprenticeship as a plumber is the equivalent of medical school. He was thinking in terms of the time spent in medical school compared to that apprenticeship; not the more like twelve years, when you count internship and residency, three times more than the apprenticeship for various tradesmen — to say nothing of the brain work, the night work, the endless studying, the great expense.

He didn't know that I had anything to do with medicine and I certainly didn't intend to tell him, because I was curious about what he might say.

I told him we were putting up a little studio by our house, and had paid the plumber $20.00 an hour, and the electrician $22.00, and I thought that was pretty good.

"That's nothing compared with doctors' rates." He said, "Their prices are going up so fast, you can't keep up with them."

I reminded him about the wage and price controls, saying that doctors were not only included, but limited to a 2½% increase, rather than the 5½% increase for the rest of industry. He knew absolutely nothing about this. This was the first time in our conversation that he called me a liar.

I cited figures to him — that the price index for everything, the over-all average during this period of control had gone up 13%, but that doctors' fees during that time had increased only 7%; and in spite of this, that at the end of April, when Phase IV was scheduled to end, that controls were to remain on doctors. (This conversation took place early in March).

His comment — "If there is any such ruling on doctors, they haven't been following it." In fact, he said that their prices had doubled and tripled in the last couple years, and that he could prove it. I suggested that he make absolutely sure of his comparisons, and know exactly what he is paying for, whether it's the doctor, or the laboratory, or the x-ray department, or what. I spoke of comparative costs of a jet plane now, compared to a propeller plane twenty years ago, and that you can't equate the two. Medicine, too, is changing rapidly, and you have to know whether you are buying the same thing before you compare.

He was curious about me and my business, and frequently made comments which I ignored, for I was determined not to let him know my connection with medicine. At this point, he said, "How come you know all this stuff?" I just said, "I read a lot."

Then he started again with, "Well, the people of the country sure don't trust the doctors anymore, just like me." I said, "It's funny you would bring that up just now, because I'm reading about who the public trusts. This is a graph made from polls taken in '66, '72 and '73, showing the percent of public confidence in major institutions in our country. If you weren't driving this bus, I would let you read it, but since you are driving, I'm going to read it to you. I will start at the bottom, number 10, and work up to first place:

10. Executive branch of federal government
9. Major companies
8. Press
7. U. S. Senate
6. U. S. Supreme Court
5. Organized religion
4. Military
3. Television News
2. Higher education
1. Most trusted among men is Medicine

His comment was "whose poll? Who publishes the magazine?"

So it was obvious what the next question was going to be. I have become used to curious people asking my purpose in traveling. I carry a portable typewriter in one hand, and a portfolio in the other, so it is obvious that I am not just out sightseeing. So I've worked out an answer for this situation. I start at the bottom and work up. I begin by saying: "I am a volunteer for a nationwide organization." I go from there to some of the things we are doing: the large sum collected last year for scholarships; the tons of material collected to send overseas to hospitals and physicians serving as missionaries in developing countries; the many educational and service projects that we do in our communities, and I give examples; and then if there is time left and I still have a listening ear, I say that this organization is composed of 90,000 doctors' wives who do these things because we share our husbands' concern for people.

Rarely do I use the expression that we are the Woman's Auxiliary to the American Medical Association. Not that I am ashamed of the AMA, but if I say that, I draw a blank. Almost no one has heard of our organization, so they turn off. It's a pity, considering all we do.

With the bus driver, it was becoming obvious that I couldn't hide my identity much longer. He asked again how come I knew all these things about medicine and the doctors. So I went through my routine, with some minor changes — I told him that I was a volunteer with an organization of physicians' wives, and I gave him some good examples of what we do in our communities. He listened, but the minute I stopped, he asked again what my connection was. I told him. His comment: "Wow! I sure picked the right person to talk medicine with."

"Well maybe you can tell me then," he said. "It's true, isn't it, that the AMA has the biggest lobby of any group in Washington?"

I answered, "No, you've got the wrong information there too." Then I agreed that I would tell him exactly how many men the AMA has in Washington, if he would tell me how many lobbyists his union has there.

He didn't need to be coaxed. He spoke up proudly, "Five hundred." 500! I was astonished!

So I explained that the total AMA force in Washington is five men, lobbyists if you wish to call them that, but that their biggest job is to check the approximately 2,800 bills on health introduced at each session of Congress, to be sure that these bills are in the best interests of providing good, safe medicine to the people of this country.

I also told him that the budget for this office of five men is less than 1% of the over-all budget of AMA.

"You must be lying," he said. "I've been hearing for years that the AMA has the biggest lobby in Washington." It was obvious to me that this is a part of his union indoctrination.

He had thought of one more gripe. His brother-in-law's cousin's wife had recently

been stopped to make credit arrangements before being admitted to a hospital to have her baby. He was adamant about this, AND this also he was holding against the doctor.

I asked him why.

His answer: "She was going there to have a baby; and the doctor was going to deliver it."

I told him I frequently go to a hotel to go to a meeting, but I don't blame the organization having the meeting if the hotel insists on collecting a day's rent in advance.

I also suggested that in nine months she should have had time to make credit arrangements with the hospital; and that the delivery of her baby eight hours later (which I had asked him about) wasn't that much of an emergency.

This conversation took place just a few days after HEW had decided to require pre-admission clearance on all Medicare and Medicaid patients — clearance as to *need* — decided by a committee. I told him about it, and said, "This could be a serious problem for sometimes the diseases of these aging people don't give nine months warning, only minutes."

Then I said proudly that AMA had gone to HEW and said they would sue. And at this point, HEW withdrew. And that this is the kind of thing the doctors in our country are doing for the people, and the reason that the biggest percentage of the public think the medical profession is the most trustworthy of any profession or institution in our country.

I've given you only the high spots. Our conversation had gone on intermittently for four hours. But now we were approaching my destination.

But I couldn't forget about this conversation. It made me think.

It made me think about how complex the socio-economic aspects of medicine have become, how the general public misunderstands these problems, and what all of this bodes for the future of our husbands . . . their patients . . . and all of us.

Also, it made me consider what we can do about it.

I started rethinking our national priorities for next year, wondering whether we are going in the right direction.

I would like to talk about them, to see whether you agree that if you and your counties get in back of these priorities, it could held the situation that this bus driver's conversation illustrates.

PRIORITY: Communication for Awareness, both Within the Organization, and With the Public. In five areas:

With Our Members. Do they know the answers? Do they get involved in a conversation, or do they shy away? Give them plenty of information and orientation. Help them get their facts straight, so that they are able to talk to the public. There are lots of people like the bus driver running around.

With Our Physicians' Associations. Do you sit on their councils, their committees? What about their board? If you are in on their planning, you can offer assistance, and keep them aware of your potential. Also, you can set the example for the counties to do likewise. We need more interchange, more rapport, more knowledge of what each other is doing, for it takes two, both the husband and wife. How about asking if you can work together.

With Our Communities. Do people in the community know what you are doing? Are you identified as physicians' wives while doing it?

With Other Organizations. Invite them to work with you, on a health education conference, for example. Forty other organizations cooperated for the recent AMA Quality of Life Conference.

Or you might invite them to come and tell your organization what they are doing in the health field.

With the Media. Do you get publicity? If your projects are vital, innovative, unusual, and timely, you won't have trouble getting publicity.

Do you have these kinds of projects?

PRIORITY: Family and Community Health for Identified Needs.

One thing that makes a project noteworthy in the eye of the public is NEED — immediate NEED. It doesn't help our public relations if we pick out a project that we think might be fun, and force it upon the community. But if you see a headline in the paper identifying a health need, and you immediately start a project in that area of need, you'll get publicity with no trouble, and better yet, you will develop an identity of concern for people.

So don't just say you're going to teach teen agers to be baby-sitters if you live in a community of retirees. Survey your communities, and establish the needs; then try to fill the needs. This demonstrates real concern and love for the people in your community; and not only to them, but to your members. Nobody wants to spin their wheels.

A county president reporting at a state meeting I attended recently, said that someone said she would become active again when their Auxiliary undertook a vital community project that needed heavy involvement. She wanted to really get her teeth into something.

Have you heard of the college kids who can't get jobs because they are "over-educated?" They can't find work in their field, and when they apply for a clerk's job, or other labor unrelated to their college degree, they are not accepted, for the individuals doing the hiring know that they will quit as soon as they find something more challenging.

Organizations likewise can't hold members who like a difficult job unless they've got something to offer which challenges that person. Several recent experiences have made me aware of the fact that we must provide solutions to tough problems, not just sand-box activities, if we want as members the well-educated, vitally concerned wives who desire to put their efforts where they are going to count in this crazy world of ours.

I sat beside one such woman at an open meeting in a state where I arrived a day before the workshop I came for. I sat down beside a woman who turned out to be a physician's wife. I asked if she was an Auxiliary member, and she said "No." She went on to say that she had dropped her membership because she didn't feel that the Auxiliary was involved in anything really vital. She was at the meeting representing another organization which she felt offered solutions to today's problems.

I sat beside another one at a recent meeting. She didn't know who I was; and again, I tried to get my questions answered before I told her. She turned out to be a volunteer community health educator. Although nearly my age, she had gone back to college just recently and received a degree as a health educator. She added, "I can thank the Auxiliary for inspiring me to do that." I asked her how it had come about. She answered, "In rebellion." She said that her Auxiliary was doing nothing of real worth in her community, that she wanted more expertise in her volunteerism, so she went back to school for training.

Another such individual walked out of one of our workshops last year, because she didn't find the challenge she was looking for. These women would make great Auxiliary members. Do you have a project that carries a great enough challenge to interest these women? We have a priority just built for them.

PRIORITY: Health Education. To implement action aimed toward solution of the problem of fragmented and generally inadequate health education in schools and communities, involving school curricula, adult education, coordination of presently available programs, etc.

One of every five present high school students will get VD before he gets his diploma, yet many schools teach nothing about it. In some states, laws concerning what may be taught in regard to health subjects have not been changed since the late eighteen hundreds.

Of $75 billion that Americans annually spend on health care, only one-half of one

percent goes for health education. That's a tiny little $11 million. And $79 million, almost twice as much, was spent last year on the promotion of tobacco by our government — tax money — even after the surgeon general has proclaimed that smoking is bad for health.

For this priority, we are not expecting our women to do the educating, but simply to bring visibility to the fact that this is a need, and to work with other organizations to bring about a better, all-inclusive system of teaching the things people need to know in order to be healthier, thereby bringing about a better quality of life.

Health education is probably the biggest need in our country today — comprehensive health education would solve many problems.

I will mention only one more.

PRIORITY: Membership Recruitment and Orientation.

We need voices. Voices of an informed, enlarged membership.

AMA membership went up 5,000 last year. I wonder where all of those wives are. We gained only 1,300 members last year; and that was the biggest gain in eight years.

All of us, all across the country need to work harder to justify the Auxiliary's existence to potential members. We are in an age of change and questioning — a time when established organizations, institutions, customs and traditions are under attack. The Auxiliary is no exception. Ironic, isn't it? At a time when it is more needed than ever. Beg your women to come to meetings. Tell them how much they are needed. Thank them for coming. Make them want to belong. It is the only way.

Who is going to control the future of medicine? We? Or the bus driver? His attitude is quite general. He's repeating what's he's been told, and what he's been reading in his union magazine. And others are being fed the same misinformation.

If our future is going to depend upon what these people think, we must give them the correct story. We must talk to them. It won't do us any good to talk to ourselves, like we are here today, unless you get inspired to talk to others.

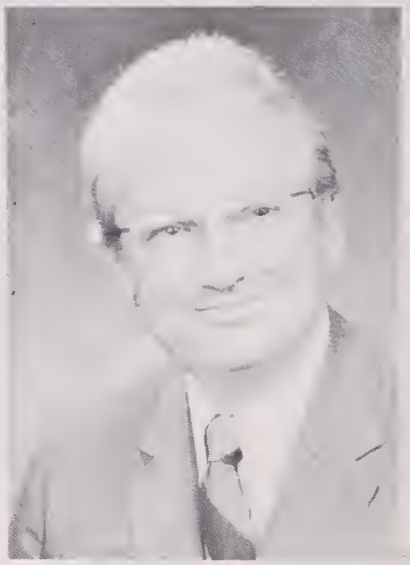
I hope you have.

I don't worry about your intelligence, and your innovative ability. You have these. You have what it takes to evaluate health conditions and to do something about them, to influence legislation and to get good people elected. You have the potential to improve the health care of America. But you must make use of that potential.

If you do, the future is bright.

I wish you the best year ever.

President's Page



CONTINUING MEDICAL EDUCATION

Historically, doctors and medical societies have taken pride in medical education. We have traditionally also taken pride in maintaining the currentness of our medical knowledge and techniques. There has always been a need for continuing medical education, but at no time in the past has this need been as important as at the present. Yet we are faced with a burgeoning technology and on all fronts the scope of our thinking and practices is increasing. Naturally, these new bodies of knowledge make it mandatory, if we are to keep abreast of medicine in the 70s, that we continue our formal and informal medical educations.

Not only does the stimulus for this continued medical education come from within the individual doctor, but there is an increasing stimulus from a multitude of external factors. At the present time we are facing increasing demands from state legislative bodies, from numerous medical and surgical specialty societies, from medical educators and from consumer groups. In the past, one of the Secretaries of Health Education and Welfare called postgraduate medical education a "crazy patchwork quilt" and labeled this relatively unorganized postgraduate medical education effort as a weakness. (It is in my opinion a strength, rather than a weakness). The point being, however, not the strength or weakness of this effort in the United States but rather that the Secretary of HEW is pushing for more in the way of postgraduate education.

Three different approaches to continued medical education have been followed in the United States by various medical organizations. Continued medical education requirements as a requisite for continued membership in a medical society was first proposed and followed by the American Academy of Family Physicians. The State Medical Society of Pennsylvania, likewise, requires proof of continued medical education as a requisite for membership. Arizona, California, and Oregon each sponsors continued medical education programs and awards certificates for proof of this education, as does the American Medical Association. The State Board of Medical Examiners in New Mexico and Maryland requires evidence of participation in continued medical education as a condition for reregistration of the license to practice.

Approximately three years ago the Medical Education Committee of the Nebraska Medical Association considered this problem but our House of Delegates considered the committee's report at that time to be too controversial, and no further action was taken. The House of Delegates did approve the Medical Education Committee's recommendation that the Nebraska Medical Association favors voluntary continuing medical education. Once again this same committee is beginning to reconsider this matter and, hopefully, within the next few months will have recommendations for our House of Delegates to consider.

None of us within the profession question the need and necessity for such programs. Of paramount concern to those of us who are somewhat closer to the legislative arena than most practicing physicians, is the obvious need for us to steer the ship of continued medical education ourselves rather than having this directed by legislative fiat. There is a genuine need for urgency in this matter.

James H. Dunlap, M.D.

Between Cases

The History.

Hydroseal.

How To Change The Accident Rate.

In an eastern state, after they put in traffic lights because there had been too many accidents, the accident rate went up.

Why I Did Not Become A Lawyer.

Not diagnosing pregnancy in time for abortion is basis for suit.

No liability for not diagnosing pregnancy in time for abortion.

Consecutive Citation headlines.

On Diseases.

Gikiyami means nanukayami.

Section On Geometry.

There are more than 300 different proofs of the Pythagorean theorem, and one was suggested by President James Garfield.

The Diagnosis.

Anemia, etiology unknown.
Hemoglobin: 17.4.

On Dying.

(a) Someone in this country just wrote a book in which he said don't tell a patient that he is dying.

(b) In Russia, the doctors never tell a patient that he is dying.

Lines To A Lady Who Has Just Had A Hysterectomy.

Your thermostack
Is out of whack.

It Figures.

The unit of magnetic flux is the Gauss; symbol B.

That Is A Big One.

The patient was also seen by Oral Surgery on this admission for a white necrotic area in the left tonsillar pillar, approximately 25 x 1 cm.

Section On Genes.

Heredity is what you believe in if you have a pretty, bright child.

Anon.

Medicine and Religion.

". . . because if He is included . . ."
They mean helium, not God.

On Surgery.

The ascending colon has been resected and anastomosed to the ileum.

On Anatomy.

Laceration occipital area each arm.

Quote Unquote.

"The young man who has not wept is a savage, and the old man who will not laugh is a fool."

Santayana.

"A man is rich in proportion to the number of things he can afford to let alone."

Thoreau.

What It Means.

Pisiform: like a pea.
Acetabulum: vinegar-cruet.
Chorea: dance.

Words We Can Do Without.

Iffy, crise.

F.C.

Picture Gallery

Scenes of the President's Dinner on October 19, 1974

The Letter Box

Dear Dr. Cole:

I am conducting a screening program for identification of hyperlipidemia in children and young adults at the University of Nebraska Medical Center, Department of Pediatrics. This project is jointly supported by the Nebraska Regional Medical Program and the University of Nebraska Medical Center.

The program consists of screening those children whose parents have suffered a heart attack/angina or stroke before the age of fifty. These children will be screened for serum cholesterol and triglyceride levels free of charge.

I would like to inform the readers of your journal of the existence of this program. I have sent a letter to various practicing physicians but it may not have reached all physicians interested in this program. I would appreciate it if you would kindly publish the accompanying letter.

Sincerely yours,
Chandra M. Tiwary, M.D.
Project Director

To the Editor:

Hyperlipidemia is an important risk factor in the development of premature atherosclerotic cardiovascular disease[1,2,3] and several investigators[4,5,6] are attempting to identify the high risk population in pediatric age groups by screening the subjects for hyperlipidemia. However the cost of measuring serum lipids in all children is formidable. It has been demonstrated in a study in Ohio[5] that screening only those children and young adults whose either or both parents had myocardial infarction before the age of 50 greatly increases the yield.

I am screening these children for elevated serum cholesterol and/or triglyceride free of charge through a Nebraska Regional Medical Program grant. If you are caring for or can identify children or young adults whose one or both parents have a history of myocardial infarction/angina pectoris. or stroke before the age of 50, I would be most happy to screen them for you and if the screen is positive then lipoproteinelectrophoresis can be arranged at no cost.

Information regarding the management of these children can also be supplied if requested.

If you would prefer to do the screening procedure at your own facility, I would appreciate knowing the results.

I would value very much the cooperation of readers of the journal for this program and would be glad to discuss the project with interested readers at their local medical meeting at no cost to them.

Please refer further inquiries to the following address.

Sincerely yours,
Chandra M. Tiwary, M.D.
Project Director
Department of Pediatrics
U. of N. Medical Center
Omaha, Nebraska 68105

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To the Editor:

The Nebraska State Medical Auxiliary hopes that every doctor in the Association will not only read this item but really do something to implement its suggestion. Most doctors have at least one blind or disabled

patient who either cannot see to read, or is unable to hold reading material. The Library for the Blind and Disabled will provide free of cost to the patient either records or tapes from which he may hear any type of reading matter he wishes, ranging from the latest magazines, through novels, detective stories, history, travel, adventure, biography, science, politics — "you name it."

The postman brings these books at no charge to the reader who is also supplied with the talking book machine on which to play them. They are read by excellent readers and provide not only wonderful entertainment but even a liberal education as well.

We beg every doctor to make life happier for his patients by referring them to the Library for the Blind and Disabled, the State Library Commission, 1420 "P" Street, Lincoln; or the Medical Auxiliary Committee in the outstate cities, for application directions.

Mary A. (Mrs. Harry) Flansburg

Dear Dr. Cole:

The opportunity to serve the state association as student delegates to its fall session was indeed a valuable one. We were grateful for the chance to gain an early understanding of some of the more critical aspects of organized medicine. Although our present appreciation of certain complex issues is certainly not complete, the chance to acquire a clearer perspective at this point in our education is important to us.

This experience has served to strengthen our basic understanding of some of the practicalities of medicine. Hopefully, we are now somewhat better equipped to meet our future obligations.

Sincerely,
Linda Cottrell
James Horrocks
Student Delegates
NMA Fall Session;
U. of N. College of Med.

Welcome New Members

Gordon D. Bainbridge, M.D.
1811 West 2nd Street
Grand Island 68801

David Baxter, M.D.
6310 Perry Circle
Lincoln, Nebraska 68516

John H. Casey, M.D.
5440 South Street
Lincoln, Nebraska 68506

Chris C. Caudill, M.D.
1512 First National Bank Building
Lincoln, Nebraska 68508

John R. Eisenach, M.D.
Clarkson Hospital
Omaha, Nebraska 68105

Richard D. Krause, M.D.
339 North Cotner
Lincoln, Nebraska 68505

William J. Lawton, M.D.
217½ North Pine
Grand Island, Nebraska 68801

Larry J. Marshall, M.D.
217½ North Pine
Grand Island, Nebraska 68801

Dale E. Michels, M.D.
2332 North Cotner
Lincoln, Nebraska 68507

David B. Policky, M.D.
510 Anderson Building
Lincoln, Nebraska 68508

Down Memory Lane

1. Those of us who received our medical school education a good many years ago, recall perhaps, that sometime during the course some instructor mentioned the fact that the human individual has a spleen; that it is located somewhere in the upper left abdomen; that it might just as well have been located somewhere else in the body as where it is; and that if it had any important function, no one seemed to know just what it was.

2. The average practicing physician does not take the life insurance examination very seriously.

3. The great achievements in medicine through which humanity has benefited have been made possible by animal experimentation. Without animal experimentation progress in medicine would come to a standstill.

4. Some impetus has recently been given to the injection of phenol in dilute solution into the thyroid gland for the cure of adenomatous and exophthalmic goiter.

5. One of the most common conditions that the physician is called upon to treat is an acute inflammatory process in the gastro-intestinal tract.

6. The need for expansion at the Nebraska University College of Medicine has been forced upon those in authority by the increasing number of persons applying for admission. There are about 360 students this year in the four grades which crowds the facilities to the utmost. About 400 applications for admission to the freshman class were filled this fall.

7. He spoke of chemistry, saying there were 92 elements in the entire world, and that the body was made up of 14 of these elements.

8. The Verges Sanitarium, Norfolk, is again in operation after a short respite during the summer.

Nebraska State Medical Journal
December, 1924

In Memoriam

EARL STANLEY PEDERSON, M.D., Ph.D.

Dr. E. Stanley Pederson was born in Pittsburgh, Pennsylvania, on June 26, 1916, and died July 31, 1974, at Omaha, Nebraska. His family moved from Pittsburgh to Omaha, Nebraska, where he attended Central High School. He received his premedical education at Creighton University and the University of Omaha and entered Medical School at the University of Nebraska in 1938 graduating in March 1943. Between his sophomore and junior years he took a year out to complete a Master's Degree in Anatomy. During his junior and senior years he was a part time research assistant in Radiology. After his internship at the University of Nebraska Hospital, he entered the U. S. Navy Medical Corps and served as a surgeon in the Pacific Theatre until his discharge in 1946.

After his discharge from the U. S. Navy, Dr. Pederson returned to the University of Nebraska where he was appointed Instructor in Anatomy while a graduate student. He was granted a Ph.D. in Anatomy in 1948 after which he continued on as a full time teacher in Anatomy until 1950 and a part time teacher until 1956 correlating gross anatomy with radiologic anatomy. Stan was highly regarded by students not only as a scholar and teacher but also as a friend and counselor.

Following a course in cytology under Dr. Papanicolau in 1950, Dr. Pederson set up the

cytology service at the University of Nebraska which he continued to supervise until 1958. In 1950 he was granted a cancer fellowship to study and correlate the histology and cytology of uterine cancer particularly its response to radiation therapy. In the course of this fellowship he became interested in Radiology, entered the training program as a fellow, and was certified by the American Board of Radiology in 1956. From 1951-1956 he served as Associate Coordinator of the Cancer Teaching Program in addition to his appointment in Radiology.

He joined the staff of the Bishop Clarkson Memorial Hospital in 1954 and become Chief of the Department of Radiology there in 1962 which position he held until his first heart attack in December of 1973. At Clarkson Hospital he had devoted an increasing amount of his time to Radiotherapy and Nuclear Medicine and in 1971 confined his practice to that field. It was a change he enjoyed because it enabled him to have more time with patients who attested to his kindness and compassion.

Dr. Pederson gave generously of his time and knowledge as a teacher of medical students and more particularly of residents in Radiology at the University of Nebraska Medical Center. His capacity to correlate basic science with clinical radiology was unique. He rose through the ranks from Instructor in 1954 to Professor of Radiology in 1968.

He was a member of the Radiological Society of North America, The American College of Radiology, his local and state medical societies, of the Phi Chi Medical Fraternity, and the Alpha Omega Alpha and Sigma XI honorary societies. Dr. Pederson was elected a fellow of the American College of Radiology in 1964.

In 1942 he married Elizabeth Ann Swanson. She and their two children, Tom and Valerie and also a foster daughter Terry Birdsong, survive him. He was a faithful member of the United Presbyterian Church.

Patriot, gentleman, friend, scholar, and physician, Dr. Pederson will be long remembered and sorely missed by his family, patients, and colleagues.

H. B. Hunt, M.D.
R. E. Bodmer, M.D.

DR. JAMES J. O'NEIL

Doctor James J. O'Neil died on October 14, 1974 at the age of fifty-five. Doctor O'Neil was born in Council Bluffs, Iowa on January 20, 1919.

He was graduated from Creighton University in 1940 and received his medical degree from the Creighton University School of Medicine in 1944.

In addition to practicing medicine in Omaha, he was an Assistant Professor of Otolaryngology at Creighton University School of Medicine for several years.

He is survived by his widow, Rosemary; sons, James J., Jr., Tempe, Ariz., and Robert, Omaha; sisters, Mrs. Ruth Sloan, Omaha; Rose O'Neil, Pittsburgh, Pa., Sister Mary Julian, Kansas City, Mo.; brother, Phillip, Council Bluffs; and two grandchildren.

DR. LOUIS T. DAVIES

Doctor Louis T. Davies died October 11, 1974 at the age of fifty-nine. Doctor Davies was born in Hooper, Nebraska on November 7, 1914.

He was graduated from the University of Nebraska in 1935 and received his medical degree from the University of Nebraska College of Medicine in 1939. He served his internship in Chicago and completed a residency in surgery at the Mayo Clinic in 1945.

He practiced as a general surgeon in Lincoln since 1947.

Survivors include his wife, Elizabeth, two daughters, Mrs. Ray (Mary) Lambert of Lincoln and Mrs. John S. (Diane) Wilkinson of Danbury, Conn.; a son, Lewis J. of Jackson, Miss., a sister, Mrs. A. B. (Gertrude) Fish, of Port Orange, Fla., and a granddaughter, Laura E. Lambert.

DR. CLARK D. SPIVEY

Doctor Clark D. Spivey died on September 18, 1974 at the age of 89. Doctor Spivey was born at New Windsor, Illinois on February 24, 1885.

He was graduated from the University of Michigan in 1907 and received his medical degree from the University of Michigan Medical School in 1909.

He practiced in Missouri, Lincoln and Anselmo before enlisting in the armed services, where he practiced in Paris, France, during World War I. He returned to Anselmo and practiced there for many years.

Survivors include his wife, Aurel; four daughters, Mrs. Katherine Swan of McCook, Mrs. Virginia Schmidt of Pompano Beach, Fla., Mrs. Joan Bowers of Lincoln and Donnalee Spivey of Omaha; one son, Clark Spivey of Overton; seven grandchildren and three great-grandchildren.

DR. JOHN E. COURTNEY

Doctor John E. Courtney died on September 12, 1974 at the age of seventy-one. Doctor Courtney was born on September 14, 1903.

He was graduated from the Creighton University School of Medicine obtaining his medical degree in 1930. He had been on Creighton University's Department of Surgery Faculty since 1933.

Doctor Courtney served as President of the Omaha-Douglas County Medical Society in 1964 and as President of the medical staff at St. Joseph's Hospital in 1962.

Survivors include his widow, Ann; two sons, Michael and John of Omaha; two daughters, Mrs. Carol Weiler, New Orleans and Joan Courtney of Denver; a brother, Francis P. McPherson, Seattle, Wash., and two grandchildren.

Our Medical Schools

Dr. Bartone to England

Dr. Francis F. Bartone, Professor and Chairman, Department of Urology, University of Nebraska Medical School, is presently on a six month sabbatical, studying pediatric urology at the Alder Hey Children's Hospital in Liverpool, England.

Creighton appoints

Dr. Joseph M. Holthaus, Dean of Creighton University's School of Medicine, has announced the following appointments and promotion:

APPOINTMENTS

Peter W. Bickers, M.D., Clinical Instructor in Pediatrics

Kewal K. Verma, B.S., Clinical Instructor in Family Practice

Richard D. Shannon, M.D., Assistant Instructor in Urology

Michael R. Marshall, M.D., Clinical Instructor in OB/GYN

Charles A. Brown, M.D., Clinical Instructor in OB/GYN

Leiberg F. Meyer, M.D., Clinical Instructor in Ophthalmology

PROMOTION

Duane E. Spiers, Ph.D., Associate Clinical Professor of Psychiatry and Neurology

Women of the year

Dr. Matilda McIntire, Director of Creighton's Department of Community Pediatrics, and Ms. Maxine Burch, Instructor in Obstetrics and Gynecology, have received "Women of the Year" awards for their work in science and research. The awards were presented by the Omaha Women's Political Caucus.

I Remember

THERE'S NO ROOM

I was an intern, and having been on the service before, I was in charge, when the attendings weren't there, of obstetrics. It was a very busy service in a three hundred bed hospital. But we had an arrangement whereby we could send city patients to a larger county hospital some five miles away if we had run out of beds or were dangerously close.

It was eleven o'clock at night. A friend of mine was running second ambulance duty, or second bus, as we called it. A multipara came in, in labor, and she was not expected that night, but I knew another was coming in and would deliver quickly, and I judged that we did not have enough beds.

So I told my friend to take her to the other hospital.

He complained, and stopped to do foolish things, like shaving and dressing, and started the trip.

The pains came quick and hard when they got a mile from our hospital, for I had miscalculated. There was a rule about having a birth or a death in the ambulance. You were supposed to buy beer for the house, that is, for all the house officers, because you had shown poor judgment. And even though I was not in the ambulance, the responsibility was mine.

My erstwhile friend got the woman to cross her legs, and held her, and persuaded the driver to go quickly, and they made it to the hospital. That is, they got her, on a stretcher, inside the hospital doors, before she delivered. And I heard about it over and over again, for a long, long time.

F.C.

Coming Meetings

CRIPPLED CHILDREN'S CLINIC —
December 14 — North Platte, Elks Lodge
January 11 — Norfolk, Elks Lodge
January 25 — Scottsbluff, St. Mary's Hospital

FIFTH ANNUAL MEETING OF THE AMERICAN MEDICAL SOCIETY ON ALCOHOLISM (AMSA) — December 11, 1974; San Francisco Hilton, San Francisco, California. The program will focus on types of Detoxication Programs and Problems and Resources in Alcoholism Medical Education. Write to: Claire Osman, AMSA, 2 Park Avenue, New York, N.Y. 10016.

NEBRASKA MEDICAL ASSOCIATION — Annual Session, April 27-30, 1975, Hilton Hotel, Lincoln, Nebraska.

AMERICAN CANCER SOCIETY — National Cancer Institute — National Conference on Advances in Cancer Management; Part II, Detection and Diagnosis, May 1-3, 1975, The Denver Hilton, Denver, Colorado.

AMERICAN MEDICAL ASSOCIATION — Annual Convention, June 15-19, 1975, Atlantic City, New Jersey.

NEBRASKA MEDICAL ASSOCIATION — Fall Session, October 17-19, 1975, Omaha, Nebraska.

AMERICAN MEDICAL ASSOCIATION — 29th Clinical Convention, November 30 - December 4, 1975, Honolulu, Hawaii.

WashingtoNotes

National health insurance (1)

Though Senator Russell Long (D., La.) may make an attempt to win Senate approval of his social security-catastrophic national health insurance proposal when the Congress returns in late November, most Capitol Hill observers believe such legislation's chances of passage are remote.

National health insurance (2)

The AMA is now in the process of reviewing and updating its position on national health insurance, Malcolm C. Todd, M.D., has told Washington groups.

"Our objective is to make the AMA's National health insurance proposal more flexible, while at the same time maintaining certain basic precepts," Dr. Todd said.

"If necessary, we may compromise on the method of financing we adopt. But we are not willing to fund national health insurance through an increase in Social Security taxes; nor are we willing to see the program administered by the Social Security Administration.

"We want a financing mechanism for comprehensive health insurance that will do the most at the least cost. This could involve:

—Increase employer - employee contributions for private health insurance;

—The use of general tax revenues;

—Or, an individual tax credit to be applied toward full health care protection. This latter method was, of course, the method employed in Medicredit.

"The important point is that we Cannot countenance greater fiscal and bureaucratic authority for the Social Security Administration or an increase in the Social Security tax.

"Any payroll tax, whether collected under Social Security or not, constitutes the most insidious form of taxation that can be invoked by government. It is a totally regressive tax that weighs heavily on low and middle income workers and lightly on the affluent."

Health bills

A batch of major health bills are hanging afire for the "lame duck" session of Congress starting Nov. 18. Comprehensive health planning bills have cleared Senate but not the House. Though no public utility-type regulation is in prospect, other measures strengthening government planning authority abound.

Health manpower legislation with provisions for federal service in shortage areas is through Senate. House action is expected shortly after Congress returns. There is a possibility that one or both may be stalled in conference as the Administration now wishes simple extension of present programs.

A health revenue sharing bill will be taken up again by a House-Senate conference. This measure extends state health block grants, community mental health centers, family planning, migrant health and neighborhood health center programs. It should secure Congressional enactment this year.

The HEW appropriations bill still has to be completed.

No chance is seen for passage of the Omnibus Drug amendments bill that would provide Medicare outpatient drug benefits, a Federal Formulary, and the Administration's low-cost drug plan for Medicare-Medicaid patients.

HMO

The Health Education and Welfare Department has issued final regulations on benefits and structure of Health Maintenance Organizations, giving the green light to federal grants launching the program.

The regulations set forth the rules and restrictions and benefits that must be fol-

lowed in order for organizations to qualify as HMOs and receive federal aid. The $325 million HMO program was approved by Congress in 1973.

Grants can now be made among the 125 groups that have applied for funds to conduct feasibility studies, planning and development.

The HMO Act authorizes federal support for five years "to demonstrate more broadly the concept of organizations delivering comprehensive health care services on a prepaid basis." Last year Congress appropriated $61 million. The Administration sought $60 million this year, but the Senate approved only $18 million because of a delay due to the development of the complicated regulations.

The regulations specify basic services to be provided in return for fixed payments made on a periodic basis without regard to the frequency, extent, or kind of services provided, with the payments set on a community rating system. These may be supplemented by what the regulations call "nominal copayments" limited under a variety of formulas.

Before the HMO program can be launched still more regulations will have to be completed. The most important is the statutory requirement that employers with more than 25 workers offer the employees the option of joining a qualified HMO if one is available. These proposed regulations are slated to be issued soon, but final ones are some months off.

Though suggestions were made to exempt HMOs from Professional Standards Review Organization (PSRO) authority, HEW rejected them, declaring that there is a need "to assure that suitable procedures are applied to HMO services to assure they conform to appropriate professional standards for the provision of health care applicable to other providers."

Basic HMO benefits must include:

—physicians services (including consultant and referral services by a physician);

—outpatient services and inpatient hospital services;

—medically necessary outpatient and inpatient emergency health services;

—short-term (not to exceed twenty visits), outpatient evaluative and crisis intervention mental health services;

—medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs;

—diagnostic laboratory and diagnostic and therapeutic radiologic services;

—home health services; and

—preventive health services (including voluntary family planning services, services for infertility, preventive dental care for children, and children's eye examinations conducted to determine the need for vision correction).

The assistant

Physicians, patients, and fellow workers have reacted favorably to the Physician Assistants (PA) employed in a pilot experiment by Kaiser Foundation Health Plan, according to a report on the program.

At present seven PAs are on duty at Kaiser. The first was hired in 1970, a graduate of the Duke University PA program and a former military corpsman.

The PA saw approximately 20 patients per day at the Vancouver Washington, clinic. He was given three physical examination appointments and the rest of his time was rapidly filled with treating relatively minor medical and surgical problems.

Convene abroad?

The tax reform bill before the House Ways and Means Committee has a provision to discourage professional conventions by American organizations in foreign countries.

Exempted would be Canada, Mexico, Bermuda, and the Caribbean. The taxpayer must show that it was "more reasonable for the meeting to be held outside North Ameri-

ca," to secure a business expense deduction. Not affected would be meetings announced before September 11, 1974.

Medicare

The Department of Health, Education, and Welfare has announced that commencing with the first of the new year the Medicare hospital deductible will jump to $92. The present deductible is $84.

The Medicare law requires an annual review of hospital costs under Medicare and an adjustment of the portion of the bill for which a Medicare beneficiary is responsible, if the costs have risen substantially.

When the hospital deductible amount changes, the law requires comparable changes in the dollar amounts that a Medicare beneficiary pays toward a hospital stay of more than 60 days, or an Extended Care Facility (EFC) stay of more than 20 days.

When a Medicare beneficiary has a hospital stay of more than 60 days, he will pay $23 a day for the 61st through the 90th day, up from the present $21 per day. If he has a posthospital stay of over 20 days in the ECF, he will pay $11.50 per day toward the cost of the 21st day through the 100th day, up from the present $10.50 per day.

If a beneficiary uses his "lifetime reserve" days, the extra 60 hospital days a beneficiary can use when he needs more than 90 days of hospital care in the same benefit period, will cost him $46 for each reserve day used, instead of the present $42 per day.

SCHEDULE OF UPCOMING NCME PROGRAMS

December 2 - December 15

SEX IN AGING AND DISEASE.

MEDICAL ADVANCES INSTITUTE.

FEMALE STRESS INCONTINENCE: DIAGNOSIS AND DECISION.

Books

Books reviewed

General Opthalmology, by Daniel Vaughan, M.D. and Taylor Asbury, M.D.; 334 pages, limp cover, 7 by 10¼ in; $9.50; published 1974 by Lange Medical Publications, Los Altos, California.

This is the seventh edition of this book, which first appeared in 1958. The type is good, as usual, the text is simply studied with diagrams and pictures, and the index is better than adequate.

Happily, this volume does not pretend to be a handbook, considering its size and the number of its pages, although there might have been more said about diplopia.

It is a good book and a bargain at today's prices.

F.C.

Your Blood Pressure: the Most Deadly High, by Norman M. Kaplan; hard cover; 198 pages; published 1974 by Medcom Press, New York.

The author is an M.D. and Professor of Internal Medicine at the University of Texas Southwestern Medical School at Dallas. The book is for the patient and "is intended to help your physician bring your hypertension or the hypertension of a member of your family under better control."

The text is divided into three parts and further into 10 chapters. It has an appendix (How to take your own blood pressure), a patient interview with the author, a glossary, and a good index.

The print is fine and reading is easy. There is a Foreword for you to mull over, where it says that there are not enough doctors to handle all patients properly, but if I had written a book like this, I might have wanted to say something almost like that, but then again, maybe not. There is an Introduction, of course.

If you like medical books for patients, this one is firstrate.

F.C.

Perspectives on Human Sexuality, edited by Nathaniel N. Wagner; 517 pages; $6.95; paperback; published 1974 by Behavioral Publications, New York.

The Editor is a Ph.D. and is associated with the Department of Psychology at the University of Washington. The book is divided into four sections: (1) Sex differences and the development of sexuality, (2) Psychological factors in sexual behavior, (3) Sexual behavior in cross-cultural perspectives, and (4) Studies of special populations. It is further divided into 23 essays, beginning im-

pressively with Freud's 1925-read "Some psychological consequences of the anatomical distinction between the sexes;" there are four 1973 articles. There is an index.

F.C.

Handbook of Medical Treatment, edited by Milton J. Chatton, M.D.; 640 pages; limp cover, $7.50; published 1974 by Lange Medical Publications, Los Altos, California.

The book is written by 18 authors, so they can't all get rich if you buy it; and there are 23 chapters (and a four-part index), which comes to about 30 cents a chapter and 40 cents per author. It is a real handbook, and it is in its 14th edition, having first appeared in 1949, being revamped every two years. The type is good, and the index is very good; there is a smattering of figures.

The text is thorough and well written; shock is good, I could not find polymyalgia but it may be there; just about everything else is.

A very good buy, 12½ ounces for $7.50 is better than steak, and this book is well done.

F.C.

Medicinews

Conference begins on health services act

Conferees have begun to discuss H.R. 14214, the Health Services Act of 1974. Included in this bill are provisions to extend federal support for community mental health centers, migrant health centers, specific authority for community health centers and block grant authority to the states to be used for public health services. (The Community Health Centers were formerly referred to as Neighborhood Health Centers and were funded under general authorities within the PHS Act). The Senate-passed version of this legislation contains additional programs to establish home health services where they are not presently available, a Commission on Mental Health and Illness of the Elderly, and a Commission on Epilepsy. It would further establish a program of rape prevention and control a network of hemophilia treatment centers.

Health manpower

Due to the recess Congress will defer action on major programs regarding federal assistance to medical schools and students of the health professions. The Senate has passed a compromise bill, S. 3585, the Health Manpower Shortage Area Assistance Act of 1974. (For a discussion of the Senate bill, see LR September 27, 1974). The House Subcommittee on Public Health and Environment has reported similar legislation, H.R. 17084, the Health Manpower Act of 1974. However, the House manpower legislation has not yet been considered by the full Interstate and Foreign Commerce Committee. The House bill would continue the system of capitation funding to medical schools at a level of $2,100 per year for each full time student. The application for such funding would have to include assurances from the medical school that the school will enter into a legally enforceable agreement with each student enrolled after June 30, 1975, which would have the student agree to pay the government an amount equal to the capitation funding which the school received by virtue of his enrollment. Among the other requirements for capitation funding is the requirement that schools of medicine continually increase their enrollment. The House Subcommittee has also reported H.R. 17085, an extension of the Nurse Training Act.

Health planning

Another major issue pending in Congress is legislation to extend and modify the former CHP and RMP and various other Public Health Service Act authorities. The House Interstate and Foreign Commerce Committee has approved H.R. 16204, the National Health Policy, Planning, and Resources Development Act, and the Rules Committee has cleared the measure for floor debate. House consideration of the bill is expected to begin soon after Congress reconvenes. The bill

would divide the nation into health service areas, and would establish a system of health planning agencies at the local, state and national levels. State and local agencies would review health services provided through health institutions and work to eliminate such services when they were found to be unnecessary. The Senate is considering similar public utility-type legislation, and the Labor and Public Welfare Committee has ordered the report of S. 2994, the National Health Planning and Development Act. The report is expected to be filed by special permission during the election recess. The Senate bill in addition to dividing the country into health service areas, would further authorize public utility-type rate setting. (For a discussion of the Senate bill see LR October 4, 1974).

Medicare

HEW Secretary Caspar W. Weinberger has adopted final regulations establishing deadlines for filing requests for services reimbursable on a reasonable cost basis under Medicare.

The services to which the deadlines apply include those furnished by hospitals, skilled nursing facilities, and home health agencies participating in the Medicare program, and emergency hospitals and hospitals outside the United States. Under the regulations, a request for payment should be filed by the end of the calendar year following the year in which the services were furnished. The same provisions now in use in Part B of Medicare govern the payment for physicians' services reimbursable on a reasonable charge basis.

The deadline is extended, however, if failure to file is due to an error or misrepresentation of the Social Security Administration or its agents; in such cases the request can be filed within 6 months after the month the error was corrected.

For purposes of the deadline, services performed in the last three months of a calendar year are counted as performed in the following year; this means that reimbursement requests for services furnished in October through December can be submitted within the following two-year period.

Intellectual Development in Shunted Hydrocephalic Children — A. J. Raimondi (2300 Children's Plaza, Chicago 60614) and P. Soare. Am J Dis Child 127:664-671 (May) 1974.

The results of a prospective study of the intelligence of 200 shunted hydrocephalic children are presented. The following five diagnostic categories were used: internal hydrocephalus, with meningomyelocele, with porencephaly, external, and Dandy-Walker cyst. The group with meningomyelocele was brightest and the group with porencephaly the dullest, and whites scored higher than blacks. The following groups were found to be of normal intelligence: white patients with internal hydrocephalus and with meningomyelocele and black patients with meningomyelocele and with external hydrocephalus. IQ was found to be unrelated either to number of shunt revisions or severity of hydrocephalus prior to initial surgery, but was related to age at initial shunt placement and shunt function. Children with internal hydrocephalus and hydrocephalus with meningomyelocele whose shunts were kept functioning were found to be normally intelligent.

Infants Exposed in Utero to Antiepileptic Drugs — R. M. Hill et al (6720 Bertner St, Houston 77025). Am J Dis Child 127: 645-653 (May) 1974.

Infants (28) exposed to antiepileptic agents during gestation have a clustering of physical findings which make them an identifiable population among neonates. Disfiguring or life threatening malformations occurred more frequently in these infants when compared to a cohort population (165) as did failure to thrive and Gesell developmental quotients of less than 90 at 21 months of age or older. More commonly used agents and their metabolites were excreted by the neonate for 2 to 12 days after birth. The dihydrodiol metabolites of phenobarbital, mephobarbital and diphenylhydantoin which are formed by the expoxide-diol pathway were identified. Since epoxides are reported to be carcinogenic, mutagenic, cytotoxic and possibly teratogenic, their formation by neonates should be noted.

REPORTS OF OFFICERS, DELEGATES AND COMMITTEES

FALL SESSION

October 3, 4 and 5, 1974

(These reports appear as originally submitted. For the House of Delegates deliberations, possible changes, and final action, refer to the minutes which follow these reports).

REPORT OF THE BOARD OF DIRECTORS

Russell L. Gorthey, M.D., Lincoln, Secretary-Treasurer; Charles F. Ashby, M.D., Geneva; Robert B. Benthack, M.D., Wayne; Dwight W. Burney, Jr., M.D., Omaha; Carl F. Frank, M.D., Scottsbluff.

As of this reporting date, the financial status of the Nebraska Medical Association continues to be in a sound position. Expenditures to date in 1974 have not exceeded budgetary allowances and with one possible exception, the Board does not anticipate unexpected disbursements. The one exception is that of the production cost of the new Relative Value Study. If the House approves production of a new Study at this Session, we will then possibly incur printing costs of that publication in 1974. Association reserves, in the opinion of the Board, however can adequately handle the financial cost of this publication. As indicated in previous reports, a definitive cost per manual will be determined for purposes of recovering printing costs.

The Board is pleased to note a continuing increase in membership at the state level. Records indicate that our membership exceeds that of 1973, with a current total of 1420. The continuation of this high level of membership assures us of a consistent level of income from membership dues.

The Board has approved effective as of July 1st of this year, a 8.7% increase in printing costs for the Nebraska Medical Journal. So far this year, the income derived for the Journal has been consistent with 1973 income.

The Board has made no changes in the investment portfolio in 1974, and has not received any recommendations for change in the portfolio from our investment consultant. Investments will be reviewed in December at the budget meeting of the Board.

In conclusion, the Board stands ready to receive any recommendations and/or comments from the House concerning the financial operations of the Nebraska Medical Association.

Respectfully submitted,
RUSSELL L. GORTHEY, M.D.,
Secretary-Treasurer

REPORT OF DELEGATE TO AMERICAN MEDICAL ASSOCIATION, ANNUAL MEETING

The following is a report of the 1974 Annual Session of the American Medical Association House of Delegates held in Chicago, Illinois at the Palmer House Hotel, June 23-27, 1974.

I. REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

1. Report Y of B of T; Report A of CC and BL and Supplement; Resolution 51; Resolution 69

This whole section of business pertained to the mechanics of methods of election of the Board of Trustees.

Report A of the Council on Constitution and Bylaws was amended and adopted in lieu of Report Y of the Board of Trustees and Resolutions 51 and 69, and in essence this provides for an at-large election to fill each vacancy on the Board of Trustees. Each officer of the Association is elected separately.

2. Report H of the B of T; Report C of the CC and BL

Report C of the Council on Constitution and Bylaws was filed and Report H of the Board of Trustees was referred to the Council on Constitution and Bylaws and a further report will be received in Portland in December. Both of these reports pertain to specialty representation in the AMA House of Delegates and is important to all members since any time the House of Delegates exceeds 250 members, the ratio of representation drops from one delegate per thousand to one delegate for each 1,250 members.

3. Report B of the CC and BL

This report recommended against forming a nominating committee to fill vacancies for councils of the House of Delegates. The recommendation against the nominating committee was adopted.

4. Report A of CLRP and D; Resolution 5

This item pertained to intern and resident membership in the AMA and for now membership for interns and residents will remain as is, that is requiring membership through a constituant association.

5. Report C of the CLRP and D

This report was adopted and recommends against the concept of creating special sections of membership and provision for representation of any such group in the House of Delegates. This is important in maintaining the AMA's federation concept.

6. Resolution 6, Resolution 104 and Resolution 113

All three of these resolutions pertain to assuring private practice representation in an adequate number on the Council of Medical Education. A substitute resolution was adopted requiring the Board of Trustees to inform the House on all members of the Council on Medical Education with reference to faculty appointments, percentage of time and private practice, etc. each time a vacancy occurs on the Council on Medical Education.

7. Resolution 13

This was adopted and referred to the Council on Constitution and Bylaws. This would make past vice-presidents of the AMA ex-officio members of the House of Delegates.

8. Resolution 55

A substitute Resolution 55 was adopted and is printed here because of the concern of some members of our state association representing specialties and sub-specialties.

RESOLVED, that the name of the Section on Plastic and Reconstructive Surgery be changed to the Section on Plastic, Reconstructive, and Maxillofacial Surgery.

9. Resolution 65

This again requested that AMA delegates run on an at-large basis within their individual state association. The resolution was not adopted because under the AMA federation concept the method of election of AMA delegates is determined by each state medical association, autonomously.

10. Resolution 66

This resolution was referred to the Council on Constitution and Bylaws. Basically it requests language be incorporated in the constitution of the AMA and the bylaws whereby interns and residents may maintain AMA membership through the intern and resident business session rather than direct membership provided for other military and government physicians.

11. Resolution 80

This resolution requested study by the Judicial Council of the matter of expulsion of members in the AMA upon conviction of a felony. Again, this resolution was not adopted because of the federation concept requiring membership to be withdrawn on a state or local level rather than a national level.

II. REFERENCE COMMITTEE A

1. Report F on Council on Medical Service; Resolution 20 (C-73)

This item of business was referred back to the Council on Medical Service since to implement this resolution would require a change in the Medicare law. Basically their request is that Medicare payment be allowed to a physician even though the physician himself does not administer or supervise the injectable medication.

2. Report C of Council on Medical Service, Renal Dialysis and Transplant Under Medicare

This is essentially a progress report on the problems associated with reimbursement of physicians for Medicare patients on dialysis. The Council feels they are making progress and did not request approval or disapproval at the present time. The report was filed.

3. Resolution 46

This resolution requests reimbursement for physicians who perform disability evaluation reports relative to the Social Security Administration. The resolution was referred to the Council on Medical Service.

4. Resolution 87

This resolution referred to the "Health Card" usage in comprehensive health insurance plans currently being proposed. In essence the House of Delegates reaffirmed the right of the physician to bill his patient directly.

5. Report G of the Judicial Council

This report was referred back to the Judicial Council for a further report at the 1974 Clinical Convention. The report seeks to answer the ethical question of year-end bonuses provided to a medical group when that bonus is dependent upon maintaining reduced utilization activities for surgical services and/or hospitalization.

6. Report of Joint Conference Committee of AMA and Blue Shield

This report referred to disagreements between the Medical Societies in New York and Blue Shield. The report was filed.

7. Resolution 24

This resolution requests encouragement by state medical associations towards the use of a universal health insurance form. Adopted.

8. Resolution 33

A substitute Resolution 33 was adopted aimed at requiring insurance companies to notify the physician prior to denying an insurance claim because of lack of medical necessity or because the claim was judged a "diagnostic admission."

9. Resolution 58

This requests the AMA develop a policy on billing for ancillary medical personnel. This request refers to more than physicians assistants and was referred to the Board of Trustees and the Council on Medical Service. A further report on this should be received in Portland in 1974.

10. Resolution 94

This resolution requests the Association to support complete maternity care of the unborn and newborn and control of reproduction in all insurance plans offered by the health insurance industry or government. This resolution was referred to the Council on Medical Service and a report is to be received at the Clinical Session in December of 1974.

11. Resolution 114

This resolution pertained to continuing difficulties some physicians are experiencing with Aetna Life and Casualty Company. The resolution was referred to the Council on Medical Service.

12. Report C of CMS; Resolution 17

This item of business referred to the physicians bill of rights and the CMS opposed the adoption of such a statement. Report C on the CMS was adopted in lieu of Resolution 17.

13. Report I of CMS

This report pertained to confidentiality of medical information and was adopted.

14. Report S of B of T

This report is a progress evaluation on the effort of the Board of Trustees to come up with model legislation to be introduced on a state level insuring confidentiality of medical records. The report is incomplete at the present time and a further report, hopefully with a draft bill, will be submitted at the 1974 Clinical Convention.

15. Resolution 30; Resolution 34

These two resolutions were aimed at seeking federal legislation insuring confidentiality of medical records. The resolutions were both referred to the Board of Trustees and the Council on Medical Service.

16. Resolution 39

This requested continued AMA effort to preserve confidential medical information. Resolution 39 was adopted.

17. Resolution 48

This resolution requests the AMA to reaffirm its stand stressing the importance of confidentiality between the patient and his physician. Adopted.

18. Report J of B of T

This is a progress report on activities of the AMA relative to PSRO. The report was filed.

19. Report B of Judicial Council

This report discusses the conflicts raised between medical ethics and professional peer review activities. This report was referred back to the Judicial Council for further study.

20. Report R of B of T; Report M of CMS

Both of these reports are background reports relative to PSRO and make recommendations as to association policy. Both reports were filed.

21. Resolutions 2, 10, 14, 15, 16, 18, 19, 21, 25, 29, 31, 37, 50, 54, 70, 75, 76, 79, 89, 91, 100, 101, 117, 118 and 123

This of course was the hottest item considered at the AMA Annual Meeting. There was much individual discussion and a full afternoon of hearings on this one item of business alone. The results of this deliberation brought out the following substitute resolution:

> RESOLVED, that this House of Delegates instruct the Board of Trustees of the Association to direct its efforts to achieve constructive amendments to the PSRO law and to insure appropriate regulations and directives, with particular effort directed at amending those sections of the law which present potential dangers in the areas of confidentiality, malpractice, development of norms, quality of care, and the authority of the Secretary of HEW; and be it further
>
> RESOLVED, that the Association should continue its efforts to achieve legislation which allows the profession to perform peer review in accordance with the profession's philosophy and the best interests of the patient; and be it further
>
> RESOLVED, that the individual state associations which elect non-participation shall not be precluded from such a position by this Association's policy statement, but should be urged to develop effective non-PSRO review programs which embody the principles endorsed by the profession as constructive alternatives to PSRO; and be it further
>
> RESOLVED, that if ongoing evaluation of the PSRO program reveals that it does, in fact, adversely affect the quality of patient care, or conflict with Association policy, the Board of Trustees be instructed to use all legal and legislative means to rectify these shortcomings.

III. REFERENCE COMMITTEE B

1. Report K of B of T

This report supports HR 8168, which would amend the Medicare law to provide for both administrative and judicial review of claims under Part B of Medicare.

2. Report L of B of T

Council on Legislation recommended against involvement in the Congressional Fellows Program. Report L adopted.

3. Report H of CMS

The House supported in principle Report H and referred it back to the Board of Trustees for development of appropriate legislation which would provide insurance for migrant workers utilizing the AMA Medicredit principles.

4. Resolution 12

This called on the AMA to encourage each state to carry out referenda on the question of prohibition of the sale and ownership of handguns. Not accepted.

5. Resolution 38

This resolution opposed HR 9125, on the basis that adequate radiation exposure controls already existed. Adopted.

6. Resolution 42

Urges the AMA to oppose the recent Internal Revenue Service ruling which makes the forgiven portion of a medical students loan a taxable income in the year in which it is "forgiven." Adopted.

7. Resolution 47; Resolution 95

A substitute Resolution 47 was adopted which was designed to broaden the involvement of the AMA in National Health Insurance without abandoning its efforts toward its own Medicredit proposal.

8. Resolution 86

This resolution calls upon the AMA and its component societies to work to detach any National Health Insurance Program from the controlling intrusions of existing PSRO laws and regulations. Adopted.

9. Resolution 90

This called on the Association to oppose nationalization of medical care. It also requested revitalization of the private practice. Referred to Board of Trustees.

10. Resolution 60; Resolution 93

Resolution 93 was amended and adopted. This puts the Association on record as seeking a 90-day response period for regulations published in the Federal Register. It also asks for provision for public hearing on request and urges the AMA to stop government by regulation rather than by legislation.

11. Resolution 64

The AMA is requested to develop legislation allowing physicians who commit themselves to the armed forces during medical school or graduate training to enjoy the bonus pay provisions of Public Law 93-274. Referred to Board of Trustees.

12. Resolution 92

Seeks an amendment to PL 92-222, the Health Maintenance Organization Act. This amendment would request that where HMO coverage is provided for employees, that they also have the option of obtaining their care by Standard Health Insurance or Health Care Service plans.

13. Resolution 116

This resolution sought removal of the Conflict of Interest Doctrine from federal utilization review requirements. Not adopted.

14. Resolution 128

This resolution was aimed at opposition to S. 3585. In the deliberations, opposition was also voiced to S. 2994, HR 12053, HR 13995, and several others. Several objectionable similar provisions exist in all these pieces of legislation which in essence create public utilities out of physicians.

Resolution 128 was referred to the Board of Trustees.

IV. REFERENCE COMMITTEE C

1. Report of C of B of T

This was a progress report on creation of a national commission on certification of physician's assistants. The commissions only concern at the present time is the assistant to primary care physicians. Filed.

2. Report D of B of T; Resolution 1

This report and resolution are aimed at the problem of maintaining competence and methods of evaluation for periodic re-certification of physicians. Both the report and resolution were adopted. This item should be of concern to the NMA Medical Education Committee.

3. Report E of B of T

This report requests the continued moratorium on state licensure of additional health occupations to the end of 1975. Adopted.

4. Report F of B of T; Resolution 105

Both this report and resolution were referred to the Board of Trustees. They both are aimed at insuring adequate representation of private practicing physicians on the medical specialty boards.

5. Report I of B of T

This presents a proposal for the Liaison Committee on Continuing Medical Education similar to the Liaison Committee existing on Undergraduate and Graduate Medical Education. Report I was adopted. Several other organizations must consider the proposal. Progress reports should be anticipated in the future.

6. Report P of B of T; Report Z of B of T

Both of these reports are aimed at development of a model contract between institution and House Staff. The final report should be received in December of 1974. Both reports were referred to the Board of Trustees.

7. Report Q of B of T

This report represents deferral of action on the question of licensure of medical school graduates until after residency is completed. This proposal originally came from a Committee of the National Board of Medical Examiners. Report filed.

8. Report AA of B of T

This is a progress report on evaluation of the foreign medical graduates. Since several medical and governmental agencies are looking at the problem of the foreign medical graduate at the present time, no action was taken. The report was filed and a further report is to be received at the 1974 Clinical Convention.

9. Report F of Judicial Council

This gives the Judicial Council approval to previous House action in regard to third party rounds. Adopted.

10. Report A of CME

This report pertains to questions of publication of specialty board testing data and financial statements. Filed.

11. Report B of CME

This is a report of implementation of Resolution 18, C-73. The report indicates that most medical school graduates have had the requested integrated clinical rotation through medical school attendance. Adopted.

12. Report C of CME

This is essentially a report of the Councils efforts to maintain quality while curricular requirements of medical education change. Adopted.

13. Report D of CME

This report is in response to a resolution requiring evaluation of requirements for medical school Board of Trustees. The report recommends against a change in present policy. Adopted.

14. Report E of CME

This report speaks of the problem of teacher preparation and effectiveness. Adopted.

15. Report F of CME

This was a report on preparation of revision of "Essentials of an Accredited Educational Program for the Physical Therapist." This report was referred back to the Council on Medical Education for study by other groups and revisions before adoption.

16. Report G of CME

This includes the essentials of an approved educational program for the surgeons assistant. Adopted.

17. Report H of CME

This report revises residencies in sub-specialty fields of pathology. Adopted.

18. Report I of CME

This report modifies the essentials of an approved internship and the essentials of approved residencies relative to medical libraries. Adopted.

19. Resolution 3

This resolution was adopted and seeks assurance that each medical discipline will be actively involved through its own mechanisms and organization when standards of graduate medical education are set or modified.

20. Resolution 4

This requests a report from the Council on Medical Education relative to the requirement to provide experience in social economic aspects of medical care and approved residencies. Referred to Council on Medical Education for report at the 1975 Annual Session.

21. Resolution 7

This resolution was modified to include the title of "Certification of Nurses in Expanded Roles." The resolution stated:

> RESOLVED, that should registered nurses require certification as evidence of their ability to perform skilled tasks within the competence and responsibility of medicine, such certification and delineation of tasks may be accomplished only with the active participation and approval of the physician representatives of the medical discipline primarily responsible for such tasks.

Adopted. This should be important to the Policy Committee and the Medical Service Committee in preparation for the 1975 State Legislature.

22. Resolution 35

This urges adoption of essentials for residency training in emergency medicine. Adopted and referred to Council on Medical Education with report requested at the 1974 Clinical Convention.

23. Resolution 44

This resolution urges the National Board of Medical Examiners to not supervise curriculum, research, or manpower distribution. Adopted as amended.

24. Resolution 56

This resolution requests the AMA to seek improved preparation for leaders in medical education and administrative duties. Referred to Council on Medical Education.

25. Resolution 67

This resolution urges the modification of definition of an accredited college, including chiropractic colleges, by the U. S. Office of Education. Referred to Board of Trustees and Council on Medical Education for report at 1974 Clinical Convention.

26. Resolution 96; Resolution 112

These resolutions were aimed at broadening the clinical experience of the first graduate year of medical education. Referred to Council on Medical Education.

27. Resolution 97

This resolution urges the name change to the Conjoint Board of Medical and Pediatric Allergy and Immunology which was intended by the House in December of 1973. Referred to Council on Medical Education.

28. Resolution 98

This resolution expresses concern for confidentiality of both academic and health records of medical students and urges the AMA to adopt a policy in this regard. Referred to Council on Medical Education.

29. Resolution 99

This requests the Council on Medical Education to evaluate the relationship between service and education. Referred to Council on Medical Education with report at 1974 Clinical Convention.

30. Resolution 111

Urges development of socio-economic programs for medical students. Adopted.

31. Resolution 119

Propose the AMA support preceptor programs in primary patient care. Adopted.

32. Resolution 120

This resolution requests the AMA to study and implement due process for medical students. Adopted and referred to Council on Medical Education.

33. Resolution 121; Resolution 122; Resolution 127

All three of these resolutions pertain to residents involved in disputes with employing hospitals, teachers, or universities. All three of these resolutions were not adopted, but the recommendation was made that the Judicial Council follow these three cases without interference and report to the House of Delegates at the 1974 Clinical Convention.

34. Resolution 124

This resolution requested unannounced inspection tours of training centers. Not adopted.

35. Resolution 125

This requested M.D. licensure of any D.O. completing an AMA approved graduate training program. Referred to Board of Trustees.

36. Resolution 126

This resolution urges adoption of the document entitled, "Guidelines for Fair, Professional Relationships Between Training Institutions and House Officers," into the essentials of approved internships and residencies. Referred to Council on Medical Education.

V. REFERENCE COMMITTEE D

1. Report C of Judicial Council; Resolution 9

Resolution 9 requests the Judicial Council to develop standards for items that could be included in a consumers guide. Report C of the Judicial Council contains items relative to advertising, relationships with HMO's and speaks to the problem of information included in community professional directories. Both Report C and Resolution 9 were referred to the Judicial Council.

2. Report B of Council on Medical Service

This is a report relative to Resolutions 55 and 56 submitted at the 1973 Clinical meeting. Report B recommends that these two resolutions not be adopted. Report B was adopted.

3. Report D of Council on Medical Service

Speaks of the problem of defining a health provider relative to comprehensive health planning legislation and determining boundaries of area wide health planning districts. Adopted.

4. Report K of Council on Medical Service

This report was rather extensively amended and then adopted. The report brings to the attention of the medical profession the implications and possible problems associated with identifying hospitals supposedly superior in specific disease categories. The amended report was adopted.

5. Report L of Council on Medical Service

This is a progress report on AMA efforts to modify the QAP program. Filed.

6. Resolution 11

Requests the Board of Trustees to make recommendations increasing "availability and accessability" of health services for disadvantaged. Referred to Board of Trustees.

7. Resolution 40

This is a resolution aimed at Blue Shield and government relative to procedural code numbers. This resolution was amended, adopted and referred to the Board of Trustees.

8. Resolution 41

This is a resolution recommending exchange of physician information relative to his hospital privileges and medical society status between hospital staffs, etc. Referred to Board of Trustees.

9. Resolution 45

This is a resolution in opposition to pre-hospital admission certification. Adopted.

10. Resolution 49

Recommends change in the Medicare law to allow for direct admission of a patient to a nursing home without prior hospitalization. Referred to Board of Trustees.

11. Resolution 63

This is a resolution recommending improved liaison and communication between medical societies both local and state and hospital staffs. Amended and adopted.

12. Resolution 72

This resolution was amended and referred to the

Council on Medical Education. It calls for AMA support of Community Medical Education Programs and Area Health Education Centers. This resolution should be important to the Policy Committee and is pertinent to some of the programs apparently financed in Nebraska through Regional Medical Programs.

13. Resolution 107

This calls for JCAH review of VA hospitals and utilization review in VA hospitals under the same standards as for private community hospitals. Adopted.

14. Resolution 22; Resolution 84

This resolution was amended and adopted with a report requested for the 1974 Clinical Convention. Essentially this resolution requests due process for physicians employed in medico-administrative positions by hospitals.

15. Resolution 82

This resolution requests that the erroneous legal interpretations of the Darling Case be corrected and proper interpretation be formulated into a statement for distribution to medical societies, hospitals, etc. Adopted.

16. Resolution 83

This is a resolution requesting study of the problems created by hospital board appointments of chiefs of medical services in hospitals. Resolution was amended and referred to the Board of Trustees for report back to the House at the 1974 Clinical Convention.

17. Resolution 103

This resolution requests dissemination of information that JCAH requirements do not state that hospital privileges be minutely detailed. Adopted.

18. Report A of Council on Medical Service

This report which is a fairly large booklet was amended and adopted. This essentially replaces a publication last created in 1964, and is a very important document for all hospitals and medical schools. Every medical staff, every hospital governing board should have access to this very important document.

VI. REFERENCE COMMITTEE E

1. Report M of Board of Trustees

This is a report referable to the American Blood Commission national blood program and it recommends support of the program by AMA, state and local medical societies. Adopted.

2. Report N of Board of Trustees; Resolution 110

Report N was adopted in lieu of Resolution 110. Basically this report recommends the development of proficiency of all physicians in basic Cardio-Pulmonary Resuscitation.

3. Report T of Board of Trustees

This is a summary report on the AMA's previous policy statements relative to venereal disease control and recommends endorsement of the use of condoms as an effective preventive method. Adopted as amended.

4. Report V of Board of Trustees

This is a result of a survey which was taken to determine the effect of sickle-cell trait on issuance of health and life insurance policies. Filed.

5. Report D of Judicial Council

This is a report on ethical principles and considerations in artificial insemination. Adopted.

6. Report E of Judicial Council

This is a summary of ethical considerations in medical research involving human subjects. Adopted.

7. Report J of Council on Medical Service; Resolution 78

This report and this resolution were aimed at providing precise definitions on cosmetic versus restorative and reconstructive treatment in surgery. These two items were both referred back to Council on Medical Services.

8. Resolution 8

This resolution urges efforts be made to require labeling of foods as to cholesterol, saturated and unsaturated fat contents on packages. The resolution was amended and adopted.

9. Resolution 20

This is a resolution in support of the American Pharmaceutical Manufacturing Industry. A substitute Resolution 20 was adopted.

10. Resolution 23

Requests the federal government to oppose cultivation of the opium poppy in Turkey. Not adopted.

11. Resolution 27

This resolution opposes repeal of the anti-substitution laws. A substitute resolution in this regard was adopted.

12. Resolution 32

This opposes changes in the nomenclature in clinical chemistry. Adopted.

13. Resolution 43

This condemns public policies which coerce patients into elective surgery such as sterilization and abortion. A substitute Resolution 43 was referred to the Board of Trustees.

14. Resolution 57; Resolution 71; Resolution 73

A substitute Resolution 57 was adopted in lieu of 57, 71 and 73. This substitute urges increased availability of safe and effective drugs and amendment or repeal of Public Law 87-781.

15. Resolution 68

This resolution pertains to oral treatment of gonorrhea. Referred to Judicial Council.

16. Resolution 77

This resolution recognizes that loss of brain function may be used as one criterion in the medical diagnosis of death. Adopted.

17. Resolution 115

This resolution urges that standards be followed which would allow the use of regular commercial air flights to transport low radiation medical isotopes. Amended and adopted.

VII. REFERENCE COMMITTEE F

1. Report B of Board of Trustees

This is the annual financial statement. Filed.

2. Resolution 74

This resolution was amended and adopted. It calls for the adherence to a balanced budget.

3. Resolution 52; Resolution 81

A substitute Resolution 52 was adopted. This calls for a distribution of a summary report of all

Board of Trustees meetings for each delegate, alternate delegate and state association.

4. Resolution 53
This requested some specific financial information from the AMA to the House. This information is available. It was presented at this meeting in rather good detail. Resolution 53 not adopted.

5. Report A of Board of Trustees; Resolution 62
This report and resolution were relative to the control of physicians fees. Report A was filed. Resolution 62 was adopted commending the AMA for its efforts.

6. Report G of Board of Trustees; Report B of Council on Long Range Planning and Development
Both of these reports were filed. They both pertain to initial efforts to formalize long range planning.

7. Report U of Board of Trustees
This report recommends regional scientific sessions of the AMA. A change in the bylaws is necessary to accomplish this objective. Report U adopted.

8. Report of Committee on Membership Opinion Polls
This report requests the committee form a poll of members on an annual basis. Adopted.

9. Report O of Board of Trustees
This is a report on the AMA's disability insurance program. Filed.

10. Resolution 61
This asks for a Public Affairs Committee appointed by the Board of Trustees. Referred to the Board of Trustees.

11. Resolution 36
This requests the development of paid advertisement and spot announcements for television to improve the physician image. Referred to Board of Trustees.

12. Resolution 88
This requests the AMA make available the AMA Newsletter as an optional publication. The House recommended its state associations duplicate the Newsletter and make it available to as many members as they desire.

13. Address of the President
Filed.

14. Resolution 129
A substitute Resolution 129 was adopted and referred to the Board of Trustees requesting nationwide public education on the problems of malpractice, commits the AMA to further efforts at prevention of malpractice, etc. The NMA Insurance Committee should be aware of this resolution.

VIII. REFERENCE COMMITTEE G

7. Report X of B of T
This report endorses Immunization Action Month 1974 and urges state and county medical society support and participation. Adopted.

2. Resolution 26
This recommends each state assign a practicing physician to each AMA-ERF medical student recipient. Referred to AMA-ERF Board of Directors.

3. Resolution 28
This requests review by the Judicial Council of previous opinions relative to charging interest rates for delinquent accounts by physicians. Adopted.

4. Resolution 102
This again encourages all AMA members to also be members of AMPAC. Adopted.

5. Resolution 106
This requests an individual's name be attached to each resolution submitted to the House. Filed.

IX. REFERENCE COMMITTEE H

1. Report W of Board of Trustees
This is a progress report on efforts of development of standards for occupational medical services under the Occupational Safety and Health Act of 1970. Adopted.

2. Report E of Council on Medical Service
This encourages each state medical society to form professional-lay organizations to coordinate activities of health oriented groups in the state. Adopted.

3. Report of AMA-ERF
This is a review of activities of this organization over the past year. Filed.

4. Resolution 59
An amended Resolution 59 was adopted. It requests that each constituent medical society reevaluate their dues structures for interns, residents and medical students.

5. Resolution 85
This urges the AMA to seek liaison with other groups. Resolution 85 not adopted.

6. Resolution 108
This resolution calls for better communication with sponsors of reports and resolutions that have been adopted by the AMA or referred to various councils and committees. Amended and adopted.

7. Resolution 109
This commends and supports the American Association of Medical Assistants. Adopted.

ELECTIONS

President Elect — Max H. Parrott, M.D.
Vice President — Joseph M. Ribar, M.D.
Speaker — Tom E. Nesbitt, M.D.
Vice Speaker — William Y. Rial, M.D.

Trustees:
James M. Blake, M.D.
Daniel T. Cloud, M.D.
Hoyt D. Gardner, M.D.
Raymond T. Holden, M.D.
Frank J. Jirka, M.D.
Joe T. Nelson, M.D.

Council on Constitution and Bylaws
Urban H. Eversole, M.D.
Herman J. Smith, M.D.

Council on Medical Education
John M. Connar, M.D.
Charles Verheyden, M.D.
Joseph M. White, M.D.

Council on Medical Service
Paul W. Burleson, M.D.
Douglas Hiza, M.D.
Robert T. Kelly, M.D.
John G. Morrison, M.D.

Judicial Council
Samuel R. Sherman, M.D.

Respectfully submitted,
ROGER D. MASON, M.D.
Delegate to AMA

REPORT OF THE EXECUTIVE SECRETARY

The Nebraska Medical Association has continued to experience a high level of activities during the past year. Numerous conferences, committee meetings and consultations have absorbed the time of officers, committees and staff. The results and conclusions of many of these activities are enumerated in reports contained in the Handbook and therefore I will not be discussing these in this report. Each of these activities, however, does have a definitive impact on the day to day practice of medicine in Nebraska. I am pleased to see so many physicians give so willingly of their time and talent to the Association. Without such cooperation, the NMA could not meet its many commitments.

Every attempt is made to keep the membership informed of the activities of the Association, however we welcome at any time inquiries from the membership on any area of Association activities.

NEBRASKA MEDICAL FOUNDATION

The Foundation continues to grant loans on a limited basis. The rate of loans approved is usually dependent upon federal loan programs that may be available. As reported previously, the Foundation has under consideration an expanded program providing for scholarships. As soon as this program is completed, physicians will be receiving information on this new activity. For informational purposes, we include below a report on the current status of the Nebraska Medical Foundation Loan Program:

	NUMBER OF LOANS		AMOUNT	
	Since October	Total	Since October	Total
Medical Students	9	831	$13,400	$ 917,530
Other	1	229	1,100	239,500
Total	10	1,060	$14,500	$1,157,030

STATE LEGISLATION

The Nebraska Legislature held its short session in 1974, (60 days). During this session, the Association followed some 25 pieces of health related legislation. A report on these subjects is to be given by the Chairman of the Medical Service Committee.

From all indications, we can anticipate a heavy work load in the 1975 Legislature. The area of expansion of practice seems to highlight potential legislation for next year. Legislative activities are handled by the Medical Service Committee in cooperation with the specialty societies and other NMA committees being asked to assist on specific legislation. Also the committee communicates and retains liaison with other allied health organizations. The cooperation of the membership and our relationship with other allies is a key element in maintaining a successful legislative posture with the Nebraska Legislature.

NORTH CENTRAL MEDICAL CONFERENCE

The dates for the North Central Medical Conference to be held in Bloomington, Minnesota are November 2 and 3, 1974. Plans are currently under way for development of the program which usually concerns itself with current medical/socio-economic issues. These programs are of an excellent caliber and we cordially invite interested physicians to attend the conference.

MEMBERSHIP

As in past years, we submit a detailed breakdown of membership in the Nebraska Medical Association. The report for 1974 is presented in the tables following this report. The report demonstrates both the numerical status and classification of membership according to our records. We are pleased to report once again the current membership, of 1,420, is a new record for the NMA.

MISCELLANEOUS

I am pleased to report that I have been appointed to the AAMSE Advisory Committee to the Executive Vice President of the American Medical Association. The 12-member committee consists of Executive Secretaries from County, State and National Societies.

Respectfully submitted,
KENNETH NEFF
Executive Secretary

— 1973 —

Active:		
AMA	1,004	
Non-AMA	261	1,265
Life		124
Service		1
Total		1,390
Less Deceased		12
TOTAL		1,378
Potential Members		23
New Members		74
Reinstated Members		17
Total New Doctors in State, 1973		114

— 1974 —

Active:		
AMA	1,055	
Non-AMA	234	1,289
Life		130
Service		1
Total		1,420
Less Deceased		7
TOTAL		1,413
Potential Members		39
New Members		75
Reinstated Members		12
Total New Doctors in State, 1974		126

STUDENT AND ASSOCIATE MEMBERSHIP
(AMA Members)

7-1-73 through 6-30-74

Student Members:		
Nebraska	24	(7)

Creighton	10	(6)
TOTAL	34	(13)
Associate Members:		
Nebraska	28	(15)
Creighton	3	(1)
Miscellaneous	6	(5)
TOTAL	37	(21)

7-1-74 through 6-30-75

Student Members:		
Nebraska	26	(4)
Creighton	6	(2)
TOTAL	32	(6)
Associate Members:		
Nebraska	12	(6)
Creighton	1	
Miscellaneous	2	(1)
TOTAL	15	(7)

	Omaha	Lincoln	Out-State	Totals
Private Practice	513	227	570	1,310
Full-Time V.A.	25	9	8	42
Full-Time Emergency Room	18	8	--	26
Full-Time Dept. Public Institutions	9	9	12	30
Full-Time Administration	3	2	--	5
Full-Time Medical School Faculty	193	--	--	193
Retired, Disabled, Not in Practice	44	16	53	113
TOTALS	805	271	643	1,719
Residents and Interns	155*	14		

(*—List of Creighton residents and interns not yet available).

REPORT OF THE EDITOR, NEBRASKA MEDICAL JOURNAL

Volume 58 of the Nebraska Medical Journal was published in 1973. It contained 60 original articles, and as some of these were divided into several parts, because of their length, the total number was 67, and the average number of articles in each issue stood at a healthy five and a half or more. There were 86 editorials.

Many letters were received and were published, complimenting the Journal on its scientific and literary prestige. The quality of its articles remains high, and there is no shortage of incoming manuscripts.

Your Editor has been appointed to the National Advisory Committee of the Journal Group and attends meetings of this committee twice each year.

The Journal publishes pictures in all issues when possible. A new section has been started, called "I Remember." Articles printed during the past year have dealt with amphetamines, Reye's syndrome, myocardial infarction, arachnoidism, purpurs, arthritis, colitis, phenylketonuria, coronary artery, fistula, and with dozens of other subjects. Advertising appears to be larger than last year.

The Journal enjoyed a good year.

Respectfully submitted,
FRANK COLE, M.D.
Editor

REPORT OF THE AD-HOC COMMITTEE ON PSRO

Houtz G. Steenburg, M.D., Aurora, Chairman; John H. Bancroft, M.D., Kearney; Warren G. Bosley, M.D., Grand Island; James H. Dunlap, M.D., Norfolk; Allan C. Landers, M.D., Scottsbluff; Donald J. Pavelka, M.D., Omaha; Frank P. Stone, M.D., Lincoln; Carlyle E. Wilson, Jr., M.D., Omaha.

P.L. 92-603 was enacted by Congress in the Fall of 1972. Prior to its enactment, the American Medical Association vigorously opposed such action. Section 249F of this law was a sixteen-page amendment to the original act which was, in fact, a 165-page compilation of amendments to the Social Security Act. This amendment was never debated on the floor of Congress and, as such, passed unnoticed by most members of Congress. Your Ad-Hoc Committee was formed at the 1973 Annual Session of this House of Delegates and was charged with the "study of PSRO legislation and the NMA's future role, if any, in PSRO, and . . . ." We have interpreted this charge to mean that we, as an Ad-Hoc Committee, should continue a general surveillance of PSRO with its multiple problems, and offer to you a contingency plan of action.

The current national status of PSRO implementation is one of chaos and confusion. This seems equally true both on the part of government and organized medicine and on the part of individual physicians. Currently, the government has announced the recognition of PSRO areas. Nebraska has been designated as a single area for planning purposes. The Federal legislation, as it currently stands, demands the implementation of operative machinery in each of these designated areas by January 1, 1976. Currently, bills have been introduced both at the U.S. House of Representatives and the U.S. Senate for repeal of the "PSRO law." Whether or not these legislative proposals will be successful is doubtful. In the event they are not successful, the AMA is committed to a course of attempted modification of the current law to render it less odious.

At the original meeting of the Ad-Hoc Committee on PSRO, the members expressed vehemently their desire to avoid "at all costs" participation with HEW pertaining to PSRO. The committee had, however, been charged with the study — not opposition — of PSRO, so the committee members traveled to Chicago, New Mexico, Utah, and California expending a great deal of time, travel, and money in their educational process pertaining to PSRO. We have had members of the Illinois PSRO and Utah PSRO meet with our committee on separate occasions to glean whatever information was available re PSRO. The committee is now unanimous in their opinion that Nebraska must recognize the existence of PSRO.

The committee recommends the House of Delegates: (1) Establish the Nebraska Foundation for Medical Care as previously presented to the House of Delegates in April, 1974. (2) Grant authority to the Ad-Hoc Committee on PSRO to proceed with implementation planning as outlined on the attached supplements. And, (3) Grant authority to the committee to seek planning funds preferably on

a voluntary basis and/or by membership assessment.

Respectfully submitted,
HOUTZ G. STEENBURG, M.D.,
Chairman

ARTICLES OF INCORPORATION OF NEBRASKA MEDICAL CARE FOUNDATION, INC.

I.

The name of the corporation shall be "Nebraska Medical Care Foundation, Inc." It is herein referred to as the "Foundation."

II.

The duration of the Foundation shall be perpetual.

III.

1. The Foundation is a noprofit corporation organized under the Nebraska Nonprofit Corporation Act for the following charitable, scientific and educational purposes:

To promote the general welfare and health of the people of the State of Nebraska by encouraging the distribution of medical services by its members to the people of Nebraska at at cost reasonable to both patient and physician; to preserve unto its members, the medical profession at large, and the public, freedom of choice of both physician and patient; to guard and preserve the physician-patient relationship and its innumerable benefits; to work in conjunction with the Nebraska Medical Association, a non-profit corporation, county medical societies throughout the State of Nebraska, and other organizations in developing and promoting the art and science of medicine, the protection of the public health, and improvement of the medical profession; to study objectively the strengths and weaknesses of the medical care delivery system in the State of Nebraska and work toward upgrading any deficiencies which may be found therein; to promote, develop and foster the availability of high quality health care, either alone, or in conjunction with individuals, physicians, medical societies and other professional organizations; to make available the organization's reviewing and consultative services to any organization desiring to contract for them; and to engage in any other lawful activities authorized by statute or bylaws of said Foundation.

2. No part of the net earnings of the Foundation shall inure to the benefit of any member, director, officer of the Foundation or any private individual (except that reasonable compensation may be paid for services rendered to or for the Foundation affecting one or more of its purposes), and no member, director, officer of the Foundation or any private individual shall be entitled to share in the distribution of any of the corporate assets on dissolution of the Foundation. No substantial part of the activities of the Foundation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Foundation shall not participate in, or intervene in (including the publication or distribution of statements) any political campaign on behalf of any candidate for public office.

3. Notwithstanding any other provision of these Articles of Incorporation, the Foundation shall not conduct or carry on any activities which are not permitted to be conducted or carried on by an organization which is exempt from taxation under Section 501 of the Internal Revenue Code or by an organization contributions to which are deductible under Section 170 of such Code and the Regulations thereto as they now exist or as they may be hereafter amended.

4. Upon dissolution of the Foundation or the winding up of its affairs, the assets of the Foundation shall be distributed exclusively to charitable, religious, scientific, literary or educational organizations which would then qualify under the provisions of Section 501 of the Internal Revenue Code and its Regulations as they now exist or as they may be hereafter amended.

IV.

The membership of this Foundation shall consist of the members of the Board of Directors. The administrative, business and prudential affairs of the Foundation shall be directed by a Board of Directors which shall consist of twelve (12) individuals who are the Board of Councilors of the Nebraska Medical Association, having its principal office in Lincoln, Nebraska. Every person upon becoming a member of the Board of Councilors of said Nebraska Medical Association shall be entitled to become, and shall be without other or any action or proceeding, a member of the Board of Directors of this Foundation. Whenever any member of the Board of Directors of this Foundation ceases for any reason whatsoever to be a member of the Board of Councilors of the Nebraska Medical Association, his membership on the Board of Directors of this Foundation shall immediately and automatically cease and terminate. Acceptance of membership on the Board of Directors shall be deemed to be acceptance of and intention to be bound by the Articles of Incorporation and Bylaws of the Foundation.

V.

The Board of Directors shall elect officers of the Foundation, consisting of a president, one or more vice presidents, secretary, treasurer, and such other officers as the Board determines to be necessary to accomplish the purpose of the Foundation. The offices of secretary and treasurer may be held by the same person. The officers need not be members of the Board of Directors. The Executive Secretary of the Nebraska Medical Association shall be the Executive Director of the Foundation and shall be an ex-officio member of the Board of Directors, without voting rights as a Board member.

VI.

The initial Board of Directors shall consist of the following persons:

Name	Address

VII.

The address of the initial registered office is 1902 First National Bank Building, Lincoln, Nebraska, and the name of its registered agent at that office is Kenneth Neff.

VIII.

The incorporators are:

Name	Address

EXECUTED at_____, Nebraska, this _____day of_____, 1974.

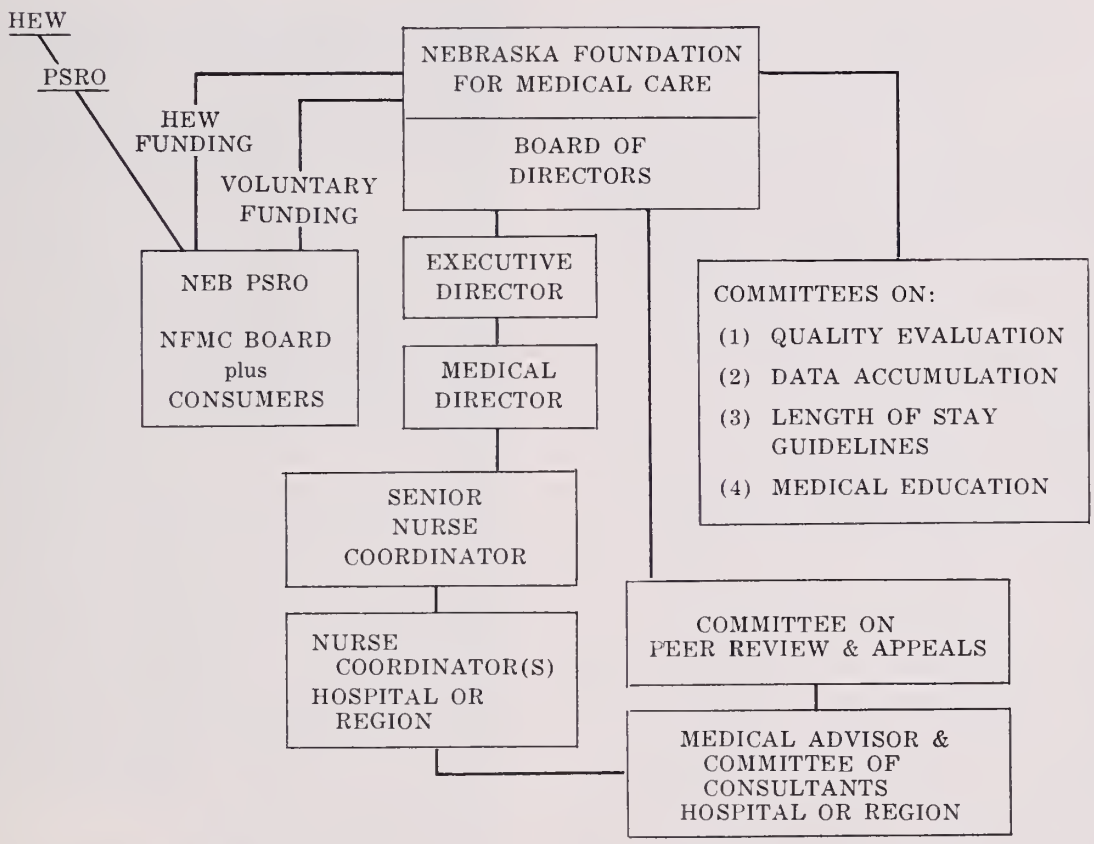
_____
Incorporator

_____
Incorporator

_____
Incorporator

_____
Incorporator

NEBRASKA FOUNDATION FOR MEDICAL CARE



MECHANISM OF PSRO

Foundation

Members of NMA + Consumers = Nebraska PSRO Organization

Nebraska PSRO

(1). Office Staff

At first NMA office staff on part-time basis plus an R.N. to oversee circuit riders.

(2) Computer and programmer

(3) Nurse Coordinators

Reviews charts, applies guidelines, encourages documentation, refers cases to medical advisor, has authority to say "yes."

Responsible to Medical Advisor in each hospital and to staff R.N.

Responsible for reviewing charts for:

(a) Admission certification, within 24 hours
   1. Applies guidelines for admission by diagnosis or problem
   2. Applies guidelines for outpatient care (or what should not be admitted)

(b) Continuing stay review
   1. Applies length of stay guidelines, flags charts 48 hours prior to dismissal time
   2. Level of care as appropriate

(c) Medical care evaluation studies
   1. Criteria sets
   2. Other short simple direct studies as may be requested

(4) Medical Advisor
Could be Chairman of the URC in each hospital.
   (a) Reviews cases referred by nurse coordinator
   (b) Contacts attending M.D.
   (c) Makes judgements
   (d) Has committee of consultants when needed
   (e) Has authority to say "no"

(5) Appeals
   (a) Submitted to the Nebraska Foundation for Medical Care Peer Review and Appeals Committee
   (b) Final appeal is via the courts

The state resume listed below indicates the current status of PSRO activity. This information was taken from AM News, July 15, 1974. We have identified in those states who have planning grants as to whether they are statewide or regional.

Alabama — Planning Contract (Statewide)
Alaska — Planning Contract (Statewide)
Arizona — Planning Contract (Area PSRO)
Arkansas — Planning Contract (Statewide)
California — Planning Contract (Area PSRO), Support Center Contract, Conditional Operating Contract
Colorado — Conditional Operating Contract
Connecticut — Support Center Contract
Delaware — Planning Contract (Statewide)
District of Columbia — Planning Contract
Florida — Planning Contract (Area PSRO)
Georgia —
Hawaii — Planning Contract (Statewide)
Idaho — Planning Contract (Statewide)
Illinois — Planning Contract (Area PSRO)
Indiana — Planning Contract (Area PSRO) Support Center Contract
Iowa — Planning Contract (Statewide)
Kansas — Planning Contract (Statewide)
Kentucky — Planning Contract (Statewide)
Louisiana —
Maine — Planning Contract (Statewide)
Maryland — Planning Contract, Support Contract, Conditional Operating Contract
Massachusetts — Support Center Contract, Conditional Operating Contract
Michigan — Planning Contract, Support Center Contract
Minnesota —Planning Contract (Area PSRO), Conditional Operating Contract
Mississippi — Conditional Operating Contract
Missouri — Planning Contract (Statewide), Support Center Contract
Montana — Planning Contract (Statewide)
Nebraska —
Nevada — Planning Contract (Statewide)
New Hampshire — Planning Contract (Statewide)
New Jersey — Planning Contract (Area PSRO), Support Center Contract
New Mexico — Conditional Operating Contract (Statewide)
New York — Planning Contract (Area PSRO), Support Center Contract
North Carolina — Planning Contract (Area PSRO), Support Center Contract
North Dakota —
Ohio — Planning Contract (Area PSRO), Support Center Contract
Oklahoma — Planning Contract (Statewide)
Oregon — Planning Contract (Statewide), Conditional Operating Contract
Pennsylvania — Planning Contract (Area PSRO), Support Center Contract
Puerto Rico — Planning Contract (Statewide)
Rhode Island — Planning Contract (Statewide)
South Carolina — Planning Contract (Statewide)
South Dakota — Planning Contract (Statewide)
Tennessee —Conditional Operating Contract (Statewide)
Texas —
Utah — Conditional Operating Contract (Statewide)
Vermont — Planning Contract (Statewide)
Virginia — Planning Contract (Area PSRO), Support Center Contract
Washington — Planning Contract (Statewide)
West Virginia — Planning Contract (Statewide)
Wisconsin — Planning Contract (Statewide)
Wyoming — Conditional Operating Contract (Statewide)

REPORT OF AD-HOC DRUG ABUSE EDUCATION COMMITTEE

Marvin Holsclaw, M.D., Lincoln, Chairman; Klemens E. Gustafson, M.D., Beatrice; Emmet M. Kenney, M.D., Omaha; Jack K. Lewis, M.D., Omaha; James I. Wax, M.D., Omaha.

The Ad-Hoc Drug Abuse Education Committee met four times during the past six months. We began early in the course of our deliberations to implement some sort of an education program for Nebraska physicians and felt that particular emphasis should be placed on bringing information to areas where drug abuse may be a problem but may not be well recognized. We made early contact with Mr. Jeff Cushner and Mr. Paul Curro of the Nebraska Drug Commission and have been working with them throughout the course of the year. Plans have been under way to develop a program in cooperation with the Nebraska Drug Commission to bring an awareness and recognition of the nature and scope of the problem to these areas in the form of a workshop of some type. The Drug Commission has voted to allocate funds in the amount of one thousand dollars ($1,000) to our committee for this purpose.

Current plans are to present a program in early November to the Four-County Medical Society at their regular meeting in Auburn, Nebraska. Plans are to bring a movie, and speaker from the membership of the Nebraska Medical Association who is involved in the drug abuse problems and also a member of the Nebraska Drug Commission and to invite key people in the community, such as school nurses, college health personnel, and people associated with local mental health organizations. This

program is intended as a pilot program and it is hoped that out of this we can develop an effective education program that can perhaps be taken to three or four other areas of the state during the remainder of the year.

Respectfully submitted,
MARVIN HOLSCLAW, M.D.
Chairman

REPORT OF EMERGENCY MEDICAL SERVICE COMMITTEE

Harris B. Graves, M.D., Waterloo, Chairman; Stephen W. Carveth, M.D., Lincoln; V. Franklin Colon, M.D., Friend; William H. Gondring, M.D., Lincoln; Floyd H. Shiffermiller, M.D., Ainsworth; Richard B. Svehla, M.D., Omaha; William Vosik, M.D., Kearney.

The committee has held several meetings since the Annual Session and has specifically discussed two subjects. One has been LB 1051, relating to certification of emergency medical technicians which was introduced in the 1974 Legislature. The bill created considerable confusion and much disagreement and was killed by the Legislature. The committee however feels this legislation will again be introduced in 1975, and for this reason is continuing its work and review on this subject.

A second subject of considerable interest to the committee is basic and advanced life support training. The committee feels this area of training is of vital importance to both the allied health professions and medicine. Because of the committee's strong interest in this area, we respectfully submit the following recommendations for approval by the House of Delegates:

1. The committee recommends that all allied health personnel be trained in basic life support.
2. The committee recommends that all hospital nursing personnel in emergency departments be trained and certified in basic and advanced life support. The committee further recommends that all physicians should be trained and certified in basic and advanced life support.
3. The committee recommends that all curriculum for allied health personnel include training in basic life support.
4. The committee recommends that a course in basic and advanced life support be held at the 1975 Annual Session of the AMA and that a preimposed test in this regard be offered to physicians in attendance. If this recommendation is approved by the House, the Emergency Medical Service Committee will prepare necessary subject matter and arrange for appropriate space.

Respectfully submitted,
HARRIS B. GRAVES, M.D.,
Chairman

REPORT OF GERIATRICS COMMITTEE

Vernon G. Ward, M.D., Omaha, Chairman; Dwight M. Frost, M.D., Omaha; Clyde A. Medlar, M.D., Columbus; Frederick F. Paustian, M.D., Omaha.

Since the report of this committee in October, 1973, no business has been presented to this committee for action.

The committee has continued its relationship with the Commission on Aging of the State of Nebraska through the Inter-Agency Panel. The Inter-Agency Panel continues to serve as a Nutrition Advisory Committee for the Nebraska Commission on Aging.

At the Inter-Agency Panel meeting on November 15, 1973, Title VII Nutrition Project applications were reviewed and recommendations were made to the Technical Review Panel.

At the Inter-Agency Panel meeting on May 17, 1974, a summary of each of the eight Title VII nutrition programs presently operating in Nebraska was given.

The Nebraska Medical Association Constitution and By-Laws charges the Committee on Geriatrics with familiarizing itself with the problems presented by the increasing number of aged persons in our population. The committee expects to cooperate with similar committees in other associations or with similar national committees interested in the problems of aging.

Respectfully submitted,
VERNON G. WARD, M.D.
Chairman

REPORT OF COMMITTEE ON HEALTH EDUCATION IN SCHOOLS AND COLLEGES

S. I. Fuenning, M.D., Lincoln, Chairman; Frank O. Hayworth, M.D., Omaha; Clyde L. Kleager, M.D., Hastings; John Latenser, M.D., Omaha; Dean A. McGee, M.D., Lexington; H. V. Smith, M.D., Kearney; Kenneth T. McGinnis, M.D., Lincoln; Mrs. Kenneth T. McGinnis, Lincoln.

This report is a brief summary of activities of the Committee on Health Education in Schools and Colleges during the period of September 15, 1973, through September 15, 1974.

This committee continues to support comprehensive health education in Nebraska schools and the need for legislative support for adequate funding.

A comprehensive health education guideline was developed by the State Department of Education for teachers. Since then four curriculum guideline supplements have been published on the following subjects: (1) The Eye and Visual Acuity; (2) You and Cancer — A Teacher Resource; (3) The Role of the School Nurse in the School's Total Health Program; and (4) Dental Health Care — A Teacher Resource.

The Nebraska Inter-Agency Health Council is sponsoring a Nebraska Conference on Health Education, November 14-15, 1974, in Lincoln. Workshops will be held in the following areas: school health education, community health education, and patient education. The purpose of the Conference is to evaluate the present state of development of health education, to determine future directions in health education and needed action for implementation. In the area of patient education, a questionnaire was sent to all physicians and health facilities to secure baseline data on the present status of patient education.

On October 4, 1970, the House of Delegates of the Nebraska Medical Association adopted a proposal for the development of an organization entitled, "Friends of the Nebraska Health Museum." Since then the Nebraska Medical Auxiliary has assumed the leadership to study health museums in

this country and their effectiveness in health education. As a result of recent conferences between the officers of the Nebraska Medical Auxiliary and the University of Nebraska administrative officials, it is now possible to proceed with the development of an organization entitled, "Friends of Nebraska Health Museums." The following action was taken by this committee upon the presentation of the above information by Mrs. McGinnis: It was moved, seconded and carried, "that in the committee's report to the House of Delegates at the Fall Session there be a recommendation that the NMA endorse the Health Museum project and support the Auxiliary in its endeavors in this regard."

As a result of the recommendation of the President's Committee on Health Education in 1972, a National Center for Health Education has now been established in the Communicable Disease Center, Atlanta, Georgia. One of the target areas identified by the new National Center is Health Education in rural areas.

It is of great interest to note that for many years the Agricultural Extension Service in Nebraska had a well trained health education specialist in Miss Helen Becker. When she retired two years ago, she was not replaced. As a result of increased attention to the need for health education, she will now be replaced and a health education specialist will again be on the staff of the Agricultural Extension Service.

Two legislative bills on health education have been recently introduced in Congress. One deals with school health education and the other with community health education.

The committee reviewed the statement on "The Role and Responsibility of Hospitals and Other Health Care Institutions in Personal and Community Health as approved by the General Council of the American Hospital Association, April 12, 1974. It also reviewed the document on "Financing of Patient Education in Health Care Institutions" as formulated by the Health Care Facilities Service of HEW.

As a result of a growing interest in all aspects of health education, various questions have been raised by the committee. It is quite apparent to the committee that more physicians need to be involved in this very important area. It is suggested therefore by the committee that sub-committees be established in the following areas: (1) School Health; (2) Health Education in Rural Areas; and (3) Patient Education. This would provide a mechanism to study these areas in depth and to provide greater leadership.

The committee last year recommended that various studies and surveys need to be done in order to give direction and also to establish the basis for the development of more effective health education programs. It is the intent to pursue the proposed Nebraska Health Education Project as outlined in last year's report.

The Chairman expresses great appreciation to all members of the Nebraska Medical Association that have provided continuous support of health education in their local area. In addition, I want to express my appreciation to members of the committee for their work throughout the year in the promotion of health and fitness in the State of Nebraska.

Respectfully submitted,
S. I. FUENNING, M.D.,
Chairman

REPORT OF THE HEALTH PLANNING COMMITTEE

Richard A. Cottingham, M.D., McCook, Chairman; James G. Carlson, M.D., Verdigre; C. J. Cornelius, Jr., M.D., Sidney; F. H. Hathaway, M.D., Lincoln; Robert G. Osborne, M.D., Lincoln; James E. Ramsay, M.D., Atkinson; C. Lee Retelsdorf, M.D., Omaha; Stanley M. Truhlsen, M.D., Omaha.

The Health Planning Committee of the Nebraska Medical Association met on six occasions in its initial year. Counsel was sought from its members as to establishing guidelines for medical services planning efforts for the state. Each member was made responsible for familiarizing himself with the proposals and recommendations deemed of value to our planning efforts from the recent Nebraska Health Project. Collectively the committee felt determination of problems and needs at the local level would be of prime value and that county medical societies and their respective councilors might help in gathering data.

An initial regional profile of medical services available and referral patterns currently in use was deemed a necessity to provide a base line for any planning proposals in the medical services area. This priority was established with attention to the recommendations to the AMA Council on Long-Range Planning and Development. A liaison meeting was subsequently held by a committee member with the Director of CHP, with attention to coordination of planning activities in the future. Contact was additionally established with the Nebraska Environmental Health Association and future meetings may occur with primary interests here in the public health (Sanitation) area.

Two committeemen represented the NMA at the CHP Seminar on Health Manpower Planning in December, 1973. A concensus was gained that there are common problems throughout the state in distribution of primary and ancillary health "provider" personnel and retention of such persons in the non-urban areas is difficult. There were no hard or fast answers, or solutions gained for this problem.

By mid-year the committee reached a decision to conduct an informational survey by a questionnaire as to the availability throughout the state of primary medical services available at the local level, facilities and ancillary medical services, ground and air ambulance availability and where cases needing common specialty referral are actually sent. A sample survey of this sort was presented to the House of Delegates at the Spring Session. The final survey instrument was developed on the basis of this and was recently mailed to 344 practitioners with a 50% return response to date. Compilation and assimilation of this data has required the services of a professional in this field, and funding has been sought via a mini-grant through the Nebraska Regional Medical Program.

Through this survey we hope to be able to identify areas which may be "under-served" by deficiencies in appropriate medical services or geography and hopefully to make solutive proposals.

Additionally liaisons were established at the Spring Session of the House of Delegates with the

Presidents and representatives of the Nebraska Dental Association, Nebraska Nurses Association, Nebraska State Department of Health and the Nebraska Hospital Association. These groups were informed of our efforts and hopes for future planning and agreements were evolved for mutual cooperation along these lines.

Our committee should like to thank Doctors John D. Coe and James H. Dunlap for their expert counsel and timely advice throughout this fledgling year. Continuing and seemingly tireless additional aid was supplied by our Executive Secretary and his most able Assistant. The majority of members on this committee and its Chairman have had the fortune to serve on prior committees whose labors bore fruit within a twelve-month period. We have had to be content with a few scratches made into an earth which seemingly has failed to shake at any time in our deliberations! Many practitioners have been kind in conveying to us their experiences with innovative medical services such as the nurse-practitioner (a reality in Kansas), physician's assistants, long-distance conveyance of laboratory and x-ray data, and numerous other service areas.

Frustration in the planning process is compounded by necessary observation of the planning professionals who are engaged in planning on a fulltime basis, largely federally funded, who are close enough to the health "consumer" to realize there is some sort of arrangement for health care, but not close enough to see or understand how our "cottage" industry of medicine operates. They seem to feel a necessity to work out a system for health care with all its ramifications and assume this would be preferable to any system in operation at the present time. Current "providers" of this health care on the other hand are largely too busy on a day-to-day basis supplying primary care to get caught up in an extensive planning process. There may well be a need in the not distant future for the assistance of a fulltime professional planner in a physician oriented program for guidance and development of our posture in these planning processes.

It is not a difficult task to define areas which are geographically or logistically deficient in medical services in this state. We must have data to support tenable positions which have had to be philosophically accepted by the native populations already there, and if possible to propose answers to gaps in services available. This group realizes that a colored pin in a map representing a primary physician is not an end point and that a simple, unlearned procedure such as myringotomy might engender a large arrow indicating ENT referral to a distant site.

We hope in further efforts in the planning processes to be intimately included in all areas of medical services planning and would seek able assistance in areas in which we lack expertise. In behalf of the committee, I should like to thank the House for the opportunity of grappling with these many challenging problems and am hopeful we can enjoy your continued support in our second year.

Respectfully submitted,
RICHARD A. COTTINGHAM, M.D.
Chairman

REPORT OF MEDICINE AND RELIGION COMMITTEE

John C. Goldner, M.D., Omaha, Chairman; Kenneth C. Bagby, M.D., Blair; W. Ray Hill, M.D., Lincoln; T. C. Kiekhaefer, M.D., Falls City; John J. Ruffing, M.D., Hemingford; Merle Sjogren, M.D., Omaha; Samuel A. Swenson, Jr., M.D., Omaha.

The Medicine and Religion Committee once again had sponsored a prayer breakfast at the Annual Meeting of the Nebraska Medical Association in Omaha, April, 1974. Because of the change in scheduling of the interim meeting in Lincoln, October, 1974, it was decided not to have a prayer breakfast at this time. It is tentatively planned to switch from a prayer breakfast to an evening dinner format at the Annual Meeting in Lincoln, April, 1975.

Your Chairman attended the Annual Regional Meeting in Chicago, February, 1974. Much interesting discussion and interchange of ideas occurred at that meeting with Medicine and Religion Chairmen from the midwest and with Mr. Arne Larson, Director of Medicine and Religion Activities for the AMA.

The Omaha Medical Society has had a functioning Medicine and Religion Committee serving primarily to coordinate activities between physicians and hospital chaplains. A number of programs have been held in the individual hospitals. We have discussed the possibility of forming an association with either or both of the medical schools in an attempt to establish input into this phase of the doctor-patient relationship during medical training. This project is still being prusued by your committee. We would hope in the near future to expand the organizational relationship between physicians and hospital chaplains in communities in Lincoln and outstate.

Your committee stands ready to undertake any activity as recommended by the House of Delegates or the officers of the Association.

Respectfully submitted,
JOHN C. GOLDNER, M.D.
Chairman

REPORT OF THE POLICY COMMITTEE

James H. Dunlap, M.D., Norfolk, Chairman; Warren G. Bosley, M.D., Grand Island; John D. Coe, M.D., Omaha; Roger D. Mason, M.D., McCook; Frank P. Stone, M.D., Lincoln.

The Policy Committee has been busy over recent months with matters of interest and importance to members of the Nebraska Medical Association. The following items are presented to the House of Delegates.

1. The Policy Committee negotiated a new conversion factor for the NMA 1965 Relative Value Study for cases covered by Nebraska Workmen's Compensation Program. Following a hearing before the judges of the Workmen's Compensation Court, the Court accepted the NMA's recommendation. This was accepted with the understanding that the NMA would renegotiate with the Court following the completion of the Association's new Relative Value Study.

2. Representatives of the Policy Committee met with University of Nebraska officials regarding the Lincoln Campus Health Center situation. It was felt that meetings with University officials were beneficial and an Advisory

Committee has been appointed to review the Health Center program and advise University administrative officials as deemed appropriate. The committee will initiate its function when a permanent Medical Director has been selected for the Center.

3. The committee spent a great deal of time considering the matter of the NMA's future relationship with Professional Standards Review Organization activities. Three members of the Policy Committee also serve on the NMA Ad-Hoc Committee on PSRO. That committee has prepared an in-depth report for the consideration of the House of Delegates at this session.

   The Policy Committee strongly urges each delegate review that committee's report in detail and that the action taken on the report be reported to each delegate's county society membership for purposes of achieving the best communication possible on this important subject.

4. The committee reviewed several items and directed their referral to various NMA committees for in-depth consideration and possible action. These subjects included: continuing medical education, medicolegal problems in Nebraska, the possibility of a new member orientation session, various proposals for legislation in the 1975 Session of the Unicameral, and the establishment of a planning mechanism for the Association.

5. The University of Nebraska College of Medicine has received considerable attention in the public eye in recent months because of multiple problems, including numerous faculty resignations. Your Policy Committee plans to meet with various University officials to offer such advice and counsel as seems proper in dealing with these multiple problems. We have attempted to avoid any posture of being meddlesome in the University activities, but at the same time have felt constrained to pursue our legitimate interests in medical matters.

6. Of all the problems facing medicine, National Health Insurance with its multiple ramifications and multiple Congressional proposals seems paramount to us. To meet this problem and to propose the proper posture and responses for the Nebraska Medical Association, we recommend that you authorize the appointment of a special Ad-Hoc Committee on NHI.

The Policy Committee has had a busy and fruitful year. We stand ready to be of service to the House of Delegates by accepting any items referred to the committee for its consideration or action.

Respectfully submitted,
JAMES H. DUNLAP, M.D.
Chairman

REPORT OF THE RELATIVE VALUE STUDY COMMITTEE

Orin R. Hayes, M.D., Lincoln, Chairman; Robert I. Burns, M.D., Columbus; Bernard L. Kratochvil, M.D., Omaha; Lyle H. Nelson, M.D., Crete; Donald F. Purvis, M.D., Lincoln; Carlyle E. Wilson, Jr., M.D., Omaha.

The Relative Value Study Committee has met on numerous occasions since the Nebraska Medical Association spring meeting and has gradually assembled what the committee feels to be a respectable Relative Value Study for the State of Nebraska. Copies of the Relative Value are available for review during the time this Fall Session is in progress.

According to the direction of the last House of Delegates meeting, the committee has attempted to establish a **Relative Value Study** for the State of Nebraska that will utilize a single conversion figure for any physician's practice. No conversion figure is suggested and the Study will not conform to other established relative value studies such as has previously been the case with the California Relative Value Study or the sub-specialty relative value studies. Within the sphere of his practice, each physician in the State of Nebraska should be able to identify a single conversion figure that will conform to his usual and customary schedule.

The committee is aware of a number of minor discrepancies within the total Relative Value Study and following acceptance of the general format by the House of Delegates, the committee will review and correct these variations. Should any member of the Medical Association find any discrepancy or wish additional procedures added, please state these recommendations in letter form and the committee will consider their correction or inclusion. In many cases, even since October of 1973, new procedures have been added that are not in the present edition of the AMA Current Procedural Terminology, the document on which this Study is based. These procedures will have to be coded under the "Unlisted Procedures" for the particular section used in the Relative Value Study. The Current Procedural Terminology will be updated regularly by the American Medical Association and the Nebraska Association will make available correction inserts as soon as the procedures are provided for.

The committee welcomes any further suggestions for improvement of this Relative Value Study but would again remind the membership that the efforts of the committee have been to assemble a **Relative Value Study** that will serve as a guide to any physician in the State of Nebraska. The membership is further cautioned to be certain that the Guidelines and Modifiers are thoroughly understood and utilized in the description of a service rendered. If the instructions are strictly adhered to, the physician will have no difficulty in identifying the scope of the medical services he has provided.

In conclusion, the committee recommends endorsement of the Relative Value Study by the House of Delegates and that it be approved for publication. Further, it must be recognized the cost of printing will necessitate the imposition of a charge for each copy of approximately $10.00, as determined by the final cost of the document.

Respectfully submitted,
ORIN R. HAYES, M.D.
Chairman

REPORT OF THE SCIENTIFIC SESSIONS COMMITTEE

Herbert E Reese, M.D., Lincoln, Chairman; Richard A. Cottingham, M.D., McCook; Randolph M. Ferlic, M.D., Omaha;

Russell L. Gorthey, M.D., Lincoln; Joel T. Johnson, M.D., Kearney; Y. Scott Moore, M.D., Lincoln; Robert M. Stryker, M.D., Omaha.

The basic format has been modified some for the Spring Scientific Sessions meeting of the Nebraska Medical Association. The Prayer Breakfast has been eliminated and in its place a Medicine and Religion Dinner at 7:00 p.m., Sunday, April 27th. Dr. Kenneth Mitchell, Director of the Division of Religion and Psychiatry Meininger Hospital from Topeka, Kansas, is the proposed speaker. It is planned this will be co-sponsored with AMA Committee on Medicine and Religion.

The basic format for Sportsman's Day and Sportsman's Annual Award Dinner is unchanged. Fun Night has been planned for East Hills with a melodrama being the entertainment.

The Scientific Symposiums have been cut to three instead of four, eliminating the Wednesday afternoon Symposium due to poor attendance in the past. Again the basic format of the Symposiums will be unchanged. Titles consist of Obesity and Nutrition, Oncology and What's New in Medicine.

Modification in the exhibits has also been made. Companies that would like to exhibit in the available space have this option or they can have the option of donating with their name in the program. The third option would be sponsoring an entire Symposium.

The Scientific Sessions Committee has discussed the rising costs of these scientific sessions. One consideration the committee was in favor of was a small fee to the members for the scientific session if rising costs would dictate.

Respectfully submitted,
HERBERT E. REESE, M.D.
Chairman

REPORT OF SUB-COMMITTEE ON ATHLETIC INJURIES

John E. Murphy, M.D., Aurora, Chairman; Stanley M. Bach, M.D., Omaha; Robert B. Benthack, M.D., Wayne; S. I. Fuenning, M.D., Lincoln; Paul Goetowski, M.D., Lincoln; Richard W. Hammer, M.D., Lincoln; Jack K. Lewis, M.D., Omaha; Charles W. Newman, M.D., Lincoln; George Sullivan, R.P.T., Lincoln; Wayne Wagner, A.T., Omaha; John G. Yost, M.D., Hastings.

Your Sub-Committee on Athletic Injuries has continued to function in an orderly manner.

The fall meeting on November 3, 1973, on "Field Recognition of Injuries," had the best attendance of any of our fall seminars in many years. Doctors Goetowski, Skultety and Jardon did an excellent job and their efforts were well appreciated. The video tape on athletic equipment and injuries was aired by most of our state television stations and many favorable comments were received. The Sports-Medicine Luncheon at the spring Annual Session of the Nebraska Medical Association, presented Doctor James Telfer of "Rx Sports and Travel," in an interesting program that everyone seemed to enjoy.

Perhaps our most important proposal has been associated with obtaining endorsement of an accreditation for a program of studies designed to lead toward recognition by the National Athletic Trainers Association, for a minor in athletic training. This is presently being reviewed by the University of Nebraska and it is felt that our proposal will receive approval. This will provide individuals with excellent background in caring for athletic injuries and rehabilitation of same, and will make these individuals available to most of our schools. We feel this is a definite step forward in meeting the demands of present national legislation by Congressman Ronald V. Dellums, Representative from California, as Bill HR 2575, "The Athletic Safety Act."

The Sub-Committee on Athletic Injuries is presently attempting to set up a fall seminar on wrestling injuries and rehabilitation of same.

Respectfully submitted,
JOHN E. MURPHY, M.D.
Chairman

REPORT OF THE PUBLIC RELATIONS COMMITTEE

William T. Griffin, M.D., Lincoln, Chairman; James S. Carson, M.D.,McCook; William S. Carter, M.D., Omaha; Donald Matthews, M.D., Lincoln; G. P. McArdle, M.D., Omaha.

This report of the committee will review activities which have been completed, those which are continuing, and also present a new proposal which has been approved by the committee for implementation.

The committee has been responsible for sending thirty-three news releases to the Nebraska media during the last twelve months. The subject matter has dealt with a wide range of topics from the progress in treatment and cure of disease to the benefits of an out-state medical practice. It is anticipated this accelerated pace of disseminating information of a news nature will be continued.

The monthly mailing of health tips to Nebraska radio stations, television stations, and newspapers has been a worthwhile project since its initiation in 1968. Thus far in 1974, 93 newspapers have used 1,137 health tips which indicates a broad spectrum of coverage for Nebraska citizens when one considers the circulation of the newspapers. When queried, the response from Nebraska's radio and television stations has been most complimentary regarding the mailing of health tips. It is anticipated this activity of sending information of a personal and public health nature will be continued.

In recent years, the President of the Nebraska Medical Association has been utilized in the recording of spot announcements for use on Nebraska's radio stations. These tapes have been disseminated twice each year and their use seems to indicate the success of this venture.

Several projects have been completed under the auspices of this committee. In an effort to increase the volume of advertisements in the NEBRASKA MEDICAL JOURNAL, an attractive rate card was prepared and is now being distributed to advertising agencies and selected businesses in the State of Nebraska. The success of this venture has not been measured at this point in time. In an effort to attract additional contributions to the Nebraska Medical Foundation Loan Program, and the new scholarship program, a brochure was developed for distribution to various agencies and individuals. (A copy is attached). In addition, the Board of Directors of the Foundation has been asked to consider a fund drive for the Foundation. More information on this will be reported at a later date.

The film entitled, "But For The Grace . . ." has been completed and eight copies have been made

available through the NMA Headquarters Office, the State Department of Health Film Library, the State Department of Motor Vehicles and the Lincoln City Library. Television stations, service clubs, and schools are being contacted and given materials regarding this film. The reaction by those persons utilizing the film to date has been most complimentary and it is felt that the use of the film will continue to increase in the coming months and years. A brochure — study guide was developed as a complement to the film and a copy is attached. It is hoped the members of this House of Delegates will help in the promotion of the film to enhance its use by local schools, service clubs, etc. Any inquiries should be forwarded to the NMA Headquarters Office.

The committee has initiated a study to determine the feasibility of producing a motorcycle safety film. It is felt that a unique approach must be undertaken if success in such a venture is to be gained inasmuch as many films on this subject are now available. A study committee is reviewing the proposal for a film and will be seeking out funding sources.

The committee's most current undertaking is the adoption of a positive public information program entitled, "Let's Hear It For Medicine USA." The main emphasis of this theme will focus on a program to educate the public on the accomplishments of American medicine. This integrated public information program will begin immediately and run through 1976 and the American Bicentennial. It is anticipated there will be involvement of local physicians and packets of prepared materials will be available to NMA members and/or county medical societies. The information will be designed for use in Nebraska's school systems as educational tools and it will vary according to the group utilizing it.

Produced radio tape messages and produced television video tapes or slide presentations will be available in conjunction with the packet of materials. It is also anticipated a travelling exhibit will be prepared which can be moved from community to community.

The basic concept, as developed by NMA President Doctor James H. Dunlap, was presented and announced in a recent NMA news release. The effort will be to acquaint people with the great benefits of the American system of private health care and how this system has led the world to a generation of unparallelled accomplishments in medicine.

The funding request for this proposal has been presented to the NMA Board of Directors for their consideration.

The committee has had a busy year and stands ready to assume any directives or ideas forwarded to us by this House of Delegates.

Respectfully submitted,
WILLIAM T. GRIFFIN, M.D.
Chairman

REPORT OF THE MATERNAL AND CHILD HEALTH COMMITTEE

Warren G. Bosley, M.D., Grand Island, Chairman; William L. Rumbolz, M.D., Omaha, Co-Chairman; Robert F. Getty, M.D., North Platte; Hodsen A. Hansen, M.D., Lincoln; L. Palmer Johnson, M.D., Lincoln; J. A. McMillan, M.D., Hastings.

Since its last report, the Maternal and Child Health Committee has had no formal meetings. However, activities have been continued.

The committee has been involved with other organizations in consideration of the need for mandatory physical examinations for children starting to kindergarten. A survey has been initiated among physicians in Nebraska to determine how well this is being done at the present time. The committee takes the attitude that this should not be mandated by law, but probably should be encouraged as a necessary part of each child's beginning school.

The committee continues to encourage the introduction of legislation which would require coverage for newborn infants from the moment of birth in all policies for health and accident insurance sold in Nebraska. The committee will in fact appear before the appropriate legislative committee in support of this bill upon its introduction.

The committee continues to maintain excellent relationships with the Maternal Child Health Division of the State Department of Health in regard to various activities relating to maternal and child health care throughout the State of Nebraska, including programs for ante-natal screening, intensive newborn care, and immunizations.

The Committee has also given support and has worked with the Department of Welfare in implementing early and periodic screening for children included under Title XIX programs, as mandated by Federal law. The Department of Public Welfare is very responsive to suggestions made by members of the committee and no conflicts have arisen in this area.

The collection of data under the Maternal Mortality Study Program continues to be effective, and reports will be presented to the Association through the Journal as we have done in the past.

Respectfully submitted,
WARREN G. BOSLEY, M.D.,
Chairman

REPORT OF THE INSURANCE AND PREPAYMENT MEDICAL CARE COMMITTEE

A. L. Smith, Jr., M.D., Lincoln, Chairman; Harold D. Dahlheim, M.D., Norfolk; Russell J. McIntire, M.D., Hastings; Paul M. Scott, M.D., Auburn; Stanley M. Truhlsen, M.D., Omaha; Hiram R. Walker, M.D., Kearney.

The Nebraska Medical Association group life insurance plan with equal amounts of accidental death and dismemberment insurance coverage, which was approved by the House of Delegates in April, 1974, is now completely described in a new brochure which will be sent out to all members. Your committee believes that it meets all of our specifications for price, coverage, and carries a $250,000 limit.

Dependents life insurance has been approved by your committee with $10,000 available to the spouse up to age 70, and $5,000 for each child from six months to 19 years with fulltime student coverage to age 23.

An additional policy of high limit accidental death and dismemberment coverage is available to our members and each spouse can be covered for the same amount.

Disability income insurance from the Western Life Insurance Company, a subsidiary of the St. Paul Companies, is now being developed by the company and should be submitted to the Insurance Commissioner of the State of Nebraska for his approval within the next month. Maximum available disability income insurance will be $2,500 per month which is the amount deemed necessary by your Insurance Committee to cover present inflationary trends. We recommend the disability income insurance program for approval by the House of Delegates.

With the approval of this report, the committee feels a sound package of coverage is now available to NMA members and their families.

The professional liability program was initiated three years ago with 308 physicians participating and now the participation is 694 physicians. Potential liability cases at this time are approximately 45 and monthly statistics are available from the insurance carrier to your committee for its study. Doctor Gilligan of Nebraska City has been a devoted and tireless worker in this field and is practically irreplaceable in the opinion of your committee. St. Paul Insurance Companies reiterates its willingness to provide speakers at any function requested by our Association or its component societies to work toward prevention and to improve the handling of potential liability cases. We believe the fine cooperation between our society and the insurance carrier is a definite step forward in promoting stability of liability coverage and in working towards a solution of the liability problem in general.

Respectfully submitted,
A. L. SMITH, JR., M.D.
Chairman

REPORT OF THE CONSTITUTION AND BY-LAWS COMMITTEE

James P. Schlichtemier, M.D., Omaha, Chairman; R. L. Cassel, M.D., Fairbury; Earl J. Dean, M.D., Hastings; Harold M. Nordlund, M.D., York; Robert D. Sidner, M.D., Kearney; John T. McGreer, III, M.D., Lincoln; Harry W. McFadden, Jr., M.D., Omaha.

The Constitution and By-Laws Committee met at the NMA offices on Thursday, September 19, 1974. Present were James P. Schlichtemier, M.D., Chairman; Earl J. Dean, M.D.; and Harold M. Nordlund, M.D. Also present were the following members of the Ad-Hoc Committee on Membership: Harry W. McFadden, Jr., M.D., Chairman; Stanley M. Truhlsen, M.D.; and Herbert E. Reese, M.D.

Several proposed changes in the By-Laws were considered. The following recommendations are made:

1. Page 12, CHAPTER 1 — MEMBERSHIP, Section 3, regarding Associate Membership.

   The wording be changed from the existing to the following:

   Section 3 — House Officer membership may be issued through a component society to House Officers and fellows in Nebraska who qualify under the licensure laws of this state and who have appointments in recognized hospitals in Nebraska and who pay dues as prescribed by the House of Delegates. Such membership shall prevail only for the period of such graduate medical training. Such membership shall entitle the holder thereof to all membership benefits and responsibilities.

   A House Officer member of this Association shall be eligible for membership in the AMA upon payment of such dues as are fixed by the House of Delegates of that Association.

2. Page 15, CHAPTER II — ASSESSMENTS AND EXPENDITURES, Section 2, regarding student and House Officer dues.

   The wording in the first paragraph be changed from the existing to the following:

   Section 2 — An annual assessment shall be levied against each active member of a component society, which shall be annual dues for membership in this Association. Dues whenever paid, shall be for the current calendar year. The dues of a House Officer member and a student member shall be prescribed by the House of Delegates.

   The remaining four paragraphs are unchanged.

3. Page 22, CHAPTER VI — DELEGATES, Section 6, regarding student membership in the NMA House of Delegates.

   The wording be changed from the existing to the following:

   Section 6 — Four student delegates shall be entitled to hold a voting membership in the House of Delegates. There will be two delegates from each school of medicine in Nebraska, comprised of students who have completed at least half of the prescribed medical school curriculum. Such individuals must be current dues-paying members.

4. Page 22, CHAPTER VI — DELEGATES, Section 7, regarding House Officer delegate membership in the NMA House of Delegates.

   The wording be changed from the existing to the following:

   Section 7 — A minimum of four delegates representing the House Officer Staff Association shall be entitled to hold voting membership in the House of Delegates. No less than two of these delegates shall be elected from the Creighton University House Staff Association and no less than two of these delegates shall be elected from the House Officers Association of the University Medical Center. Provided further that if the membership of either House Staff Association exceeds 50 members, then such Association shall be entitled to one additional delegate for each 50 members or fraction thereof. Such individuals must be current dues-paying members.

5. Page 39, CHAPTER XII — COUNCILS AND STANDING COMMITTEES AND THEIR DUTIES.

   Add Membership Committee as standing committee #24.

6. Page 47, CHAPTER XII — COUNCILS AND STANDING COMMITTEES AND THEIR DUTIES, Section 2, regarding duties of standing committees.

   Section 2 to be amended to include:

   24. The Membership Committee shall develop and implement programs for orientation and

promotion of organized medicine to the medical student, House Officer and non-member physicians in Nebraska.

Respectfully submitted,
JAMES P. SCHLICHTEMIER, M.D.
Chairman

REPORT OF AD-HOC COMMITTEE ON MEMBERSHIP

Harry W. McFadden, Jr., M.D., Omaha, Chairman; Warren G. Bosley, M.D., Grand Island; Robert J. Luby, M.D., Omaha; Herbert E. Reese, M.D., Lincoln; Houtz G. Steenburg, M.D., Aurora; Stanley M. Truhlsen, M.D., Omaha.

The Ad-Hoc Committee has met on several occasions and considered the charge given it to develop a membership program for students, house officers and non-members of the NMA. The committee first received a report on the current status of membership in the Nebraska Medical Association. The committee then discussed ideas for a membership program. It was felt by the committee that contacts of non-members should be initiated at both county and state levels of organized medicine and recommended that county societies make a determined effort to contact all new members who move to their area. Additionally, the committee suggests these individuals also be contacted by a letter from the President of the Nebraska Medical Association. It was further recommended that this contact be supplemented by appropriate materials from the Headquarters Office of the NMA. It was the opinion of the committee that early contact utilizing the above approach should be helpful in making new physicians aware of the activities and benefits they gain by joining organized medicine.

The committee next discussed ideas concerning membership orientation. It was the general concensus of the committee that it would be difficult to obtain mandatory attendance for new members at a formal orientation program. In lieu thereof, the committee concurred that new members should be contacted by letter from the President of the Association plus receiving selected information regarding membership benefit program. The committee was of the feeling that orientation programs should originate at the local society level and be augmented by the State Association. The committee offers its services in any way possible to assist the county medical societies in this activity.

The committee next discussed the need to encourage students and house officers to join organized medicine and again felt that local medical societies should take the lead in making these individuals aware of benefits and activities within organized medicine. The committee further recommends that county medical societies continue to encourage students and house officers to attend county society meetings and sponsor such attendance. Also discussed was the possibility of setting up meetings at the medical schools for the purpose of visiting with students and house officers on a direct basis. No definite plans were developed, however the committee will continue to study the development of this kind of activity.

In conclusion, it is the recommendation of the committee that all student and house officer members be eligible to participate in the fringe benefit programs developed by the Nebraska Medical Association.

Respectfully submitted,
HARRY W. McFADDEN, JR., M.D.
Chairman

PROGRESS REPORT OF NEBRASKA REGIONAL MEDICAL PROGRAM

The last Nebraska Regional Medical Program progress report to the House of Delegates indicated that 22 project proposals had been reviewed by the program and were being submitted to Washington on May 1, 1974, for funding. These 22 proposals were reviewed by the National Advisory Council and as a result of its recommendation, Nebraska was awarded $902,661 or 94 percent of the requested amount. The contract period for these projects is from July 1, 1974 to June 30, 1975.

On July 1, 1974, seven additional projects were submitted. Word was received in late August that the region had received the amount requested ($110,758) plus an additional $6,098 which could be used for mini-grants. The contract period for these seven projects is from September 1, 1974, to June 30, 1975.

Upon issuance of all contracts, the Nebraska Regional Medical Program will be monitoring over 50 different projects. This includes funds for six Community Health Education Consortias (CHEC) which blanket the state; Home Health Care Agencies and satellite programs; projects in perinatal care, diabetes, rehabilitation, hypertension, life support, EMS, medical care management, maternal and child health, nutrition and education, renal disease, dental screening, dental education, dental management for the handicapped, shared hospital resources and education, institutional pharmacy services, identification of hyperlipidemia in children, antenatal obstetrical centers, clinical electroretinography center, PSRO feasibility study, and a master medical calendar. In addition, mini-grants have been awarded for updating pharmaceutical knowledge and the early detection of hypertension.

With the resignation of the director and with a similar program being established at the University of Nebraska, the Regional Advisory Group approved the phase-out of the Drug Information Service effective July 1, 1974. At the present time, all calls are being referred to the University of Nebraska Medical Center.

The Learning Resource Center which operates out of the central office has continued its growth. In addition to its regular services, it has been instrumental in the continued development of the shared hospital groups throughout the state. Most recently the eleventh shared medical group was established in Nebraska's southern panhandle to foster quality inservice training to health care personnel in member institutions.

Dr. Francis Colgan, Coordinator for Research, Planning and Evaluation for the Nebraska State Department of Education, was elected chairman of the Regional Advisory Group and Executive Committee for the period July 1, 1974 to June 30, 1975. Dr. Carl Cornelius from Sidney will serve as Vice Chairman. Members at large of the Executive Committee are Dr. Robert Schalock, Chairman of the Department of Psychology, Hastings College; Kenneth Neff, Executive Secretary of the Nebraska Medical Association; and Pauline Tyndall, Director of Community Health Representatives for the Omaha Tribe of Nebraska.

The future of the Nebraska Regional Medical Program past June 30, 1975, is still uncertain. Legislation known as the National Health Policy

Planning and Resources Development Act of 1974 (HE 16204) has recently been reported out of the House Committee on Interstate and Foreign Commerce. This legislation would combine most of the functions of RMP, CHP, and Hill Burton, if signed into law.

Respectfully submitted,
DONALD MATTHEWS, M.D.,
Program Coordinator

Report of Board of Councilors

The Fall Session of the Board of Councilors was held October 3, 1974, Lincoln Hilton Hotel, Lincoln. The following Councilors and members were present: Drs. Louis J. Gogela, H. C. Stewart, Robert M. Sorensen, Houtz Steenburg, Lyle Nelson, Hiram Walker, Fred J. Rutt, Berl Spencer, Calvin Oba and James H. Dunlap.

The meeting was called to order by the Chairman, Dr. Steenburg.

Dr. Steenburg called for election of a Chairman of the Board of Councilors. It was moved, seconded and approved that Dr. Steenburg be reelected as Chairman.

Election of a Secretary was called for and it was moved, seconded and approved that Dr. Nelson be elected as Secretary.

Dr. Steenburg stated that an acting Councilor for the Fourth District would need to be selected as a replacement for Dr. Robert Benthack. He informed the Councilors that Dr. James Carlson had been recommended as the Councilor for this District. This recommendation was approved by the Board.

The Board of Councilors approved Dr. J. Whitney Kelley as an interim Councilor for the First District to replace Dr. Gurnett for this session.

The reports and resolutions in the Handbook were then considered. All were accepted for consideration of the House of Delegates with recommendations being made on the following reports:

Delegate to AMA — Resolution 80, Reference Committee on Amendments to Constitution and By Laws, was discussed, and the Councilors felt that the Constitution and By Laws of the NMA should have a provision for expulsion of members convicted of a felony. It was recommended that this be referred to the Constitution and By Laws Committee for review. This was approved.

Relative Value Study Committee — It was recommended that the House of Delegates approve the Relative Value Study, and that it be returned to the Relative Value Study Committee for refinement, and that it then be sent to the Policy Committee for final approval, prior to January 1, 1975, for publication. This was approved.

Insurance and Prepayment Medical Care Committee — Dr. Dunlap discussed the Medicolegal Advice Committee and the members of this committee which are elected by the Board of Councilors. He asked that the Councilors give consideration to the selection of Dr. Dwight Frost of Omaha as a member of this committee at the 1975 Annual Session.

There was also discussion of prepaid medical care plans, and it was recommended that the Insurance and Prepayment Medical Care Committee investigate, for informational purposes, the activities of all third party carriers in regard to prepaid medical care plans, and this was approved.

The list of 50-Year Practitioners and the requests for Life Membership were approved.

There being no further business, the meeting was adjourned.

Report of House of Delegates

FIRST SESSION

The first session of the House of Delegates was held October 4, 1974, at the Lincoln Hilton Hotel, Lincoln, Nebraska. The meeting was called to order by the Speaker, Dr. Harry McFadden.

The call for a quorum showed 59 delegates were present, and the House was declared in session.

Dr. McFadden called for approval of the minutes of the Annual Session House of Delegates, as printed in the July, 1974, issue of the Nebraska Medical Journal. These were approved as printed.

Oral reports were presented by the following:

Dr. Joseph M. Holthaus, Dean, Creighton University School of Medicine

Dr. Robert D. Sparks, Chancellor, University of Nebraska Medical Center

Dr. Henry D. Smith, Director, State Department of Health

Dr. Robert F. Shapiro, Chairman, Medical Service Committee

Mrs. J. Whitney Kelley, Nebraska Chairman, AMA-ERF

Dr. J. P. Gilligan, Chairman, Medicolegal Advice Committee

Reference Committee members were approved by the House, and the following committee assignments were made:

Reference Committee #1

Board of Directors
Delegate to AMA (with exception of Item 21, Reference Committee A)
Editor
Executive Secretary
Constitution and By Laws
Public Relations
Nebraska Regional Medical Program
Medical Service

Reference Committee #2

Ad-Hoc Committee on Drug Abuse
Ad-Hoc Committee on Membership
Emergency Medical Service
Geriatrics
Maternal and Child Health
Scientific Sessions
50-Year Practitioners
Life Memberships

Reference Committee #3

Relative Value Study
Health Planning
Policy Committee — Item #1
Resolution #1 — Scotts Bluff County — Relative Value Study

Reference Committee #4

Ad-Hoc Committee on PSRO
Delegate to AMA — Item 21, Reference Committee A
Policy Committee — Item #3
Resolution #2 — Lancaster County — Funding for Statewide PSRO

Reference Committee #5

Health Education in Schools and Colleges
Insurance and Prepayment Medical Care
Medicine and Religion
Policy Committee — Items #2, #4, #5 and #6
Sub-Committee on Athletic Injuries
Resolution #3 — Medicolegal Advice Committee — Educational Program

The Chair called for resolutions from the floor and the following were submitted and assigned to Reference Committees:

#4 — Omaha Medical Society — Hospital Records (Reference Committee #5)

#5 — Omaha Medical Society — PSRO Ad-Hoc Committee Report (Reference Committee #4)

#6 — Omaha Medical Society — Blue Shield H.M.P. (Reference Committee #5)

#7 — Omaha Medical Society — Presidential Honorarium (Reference Committee #1)

#8 — Dodge County — Informed Consent — (Reference Committee #2)

The following Resolution #9 was introduced by the Omaha Medical Society:

WHEREAS, Dr. John R. Schenken has been a loyal and faithful member of the Nebraska Medical Association for many years, and

WHEREAS, Dr. John R. Schenken has rarely missed a meeting of the House of Delegates of the Nebraska Medical Association, and

WHEREAS, Dr. John R. Schenken is recuperating at Methodist Hospital from surgery, be it therefore

RESOLVED, that the Nebraska Medical Association extend best wishes for a speedy and safe recovery.

It was moved that the rules be suspended and that this resolution be acted upon without referral to a Reference Committee. This was approved, and the Resolution was adopted unanimously.

The following Resolution #10 was introduced by the Sixth Councilor District:

WHEREAS, Dr. C. L. Anderson of Stromsburg is retiring and moving from the area, and

WHEREAS, he has given unselfishly of his energies and time to organized medicine in Nebraska for many years, be it therefore

RESOLVED, that the House of Delegates extend their appreciation for his years of work in the Association and wish him well in his retirement.

It was moved that the rules again be suspended and that this resolution be acted upon without referral to a Reference Committee. This was approved, and the resolution was adopted unanimously.

Dr. McWhorter informed the House that as a result of LB 1054, the University of Nebraska had received a grant for a cardiovascular educational program.

Dr. Cottingham, Chairman of the Health Planning Committee, discussed the surveys which had been mailed out. He told the House that as the cost of compiling these statistics was quite high, an application had been made to the Nebraska Regional Medical Program for a mini grant.

Dr. Dunlap made the following remarks to the House.

"With the passage of Public Law 92-603, in October, 1972, we here in Nebraska, as all across the United States, began the agonizing, scrutinizing process of surveying this law with its multiple ramifications and implications — some very real and others probably imaginary. As the time has passed, most of us have focused on three main objections to governmentally directed Professional Standards Review Organizations. In summary, our objections and very real concerns have centered upon: (1) The ever increasing encroachment of federalism into our lives; (2) The super-imposition of governmentally directed norms and standards of care; (3) The preservation of confidentiality of records.

"These three areas of concern have, to me, increased with the passage of time and with greater understanding of their malicious potential. Of the three, I consider the preservation of confidentiality of patients records to be the most important. I will not dwell further on these three items as I am certain all of you have been sufficiently tortured by them — not only within the confines of your own thoughts but by multiple speakers, probably in this very forum. There are, of course, numerous other areas within Public Law 92-603 with which we might concern ourselves with fear. Perhaps greatest among these other areas are the problems inherent in an already overworked medical litigation arena.

"As I have listened to and participated in discussions concerning PSRO between physicians in different groups and areas, certain common denominators of confusion and side-tracking of arguments seem to continually arise. For example, I totally agree that the medical profession has done a better job of self-policing than any other profession. I totally agree that other professional groups would do well if they even attempted to play catch-up with us in this regard, and I totally agree that as a physician I would personally prefer to spend more of my time dealing with patients and less of my time dealing with paper work, etc. These comments and many more, in my opinion, tend to sidetrack us from the real concern. That concern, in my opinion, is best summarized by the word 'Government.'

"Were it possible to purge the PSRO law of the Secretary of Health, Education and Welfare and of all things governmental, I believe the remainder of the law embodies principles which our profession could use to good avail. The initials PSRO

have come to stand for many things. President Ford, when speaking to the AMA House of Delegates, in Chicago, stated that these PSRO initials should mean 'Politicians Should Remain Out.' I believe additional meanings are proper, appropriate, and meaningful. They might just as well mean 'Physicians Should Remain Organized,' or 'Physicians Should Rule Ourselves.'

"Now, I would submit to you that if all references to the government could be extirpated from this law, the concept of the law would then not be invalid. The concept does augment programs which we have espoused forever. The programs of self-rule and self-policing, the programs of continuing education, the multiple programs of self-monitoring dealing with all aspects of patient care, and this most certainly must include economic monitoring and self-policing. I believe that all of us in this room will agree to these 'self' concepts.

"After having listened to the PSRO discussions literally from coast to coast in our United States and within the framework of these thoughts previously mentioned, I have formed two conclusions from which I cannot escape: (1) In my judgement, the current fact of PSRO is indisputable. This is a fait accompli. (2) No possibility exists for immediate, or in the near future, repeal of this federal law. Within the history of our United States, no federal law, at any time, has ever been repealed without first having been tried. There is no repeal precedent.

"If you will accept these conclusions and further realize that PSRO is coming to all of the United States, including the State of Nebraska, then I submit that it is in the best interests of our patients and ourselves that this PSRO effort be directed by Nebraska physicians of our own choosing, not the physicians and organization of the choosing of the Secretary of HEW.

"If we can, in Nebraska, at this time, we must accept this as a fact, and we must further accept as a fact that he who controls the finances and he who controls the records in review, will control the doctors and the type of medical care delivered.

"I believe it serves the interests of the physicians of Nebraska best if we will instruct our delegates to allow our PSRO Ad-Hoc Committee to proceed with their planning. At the present time, this committee has been authorized to continue surveillance and contingency planning dealing with the PSRO problem. I would like to see this Ad-Hoc Committee instructed to continue with implementation planning of PSRO, working on the premise that these activities will be implemented in cooperation and coordination with the State Medical Society, and the Foundation for Nebraska Medical Care as proposed at our last House of Delegates meeting — working on a fee-for-service basis, eliminating to as great an extent as possible and practical, governmental financing.

"All that has been said to date by me is a prelude to the area of my real concern, and that concern is not PSRO. My contention is that you and I have been dissuaded from focusing on that to which our efforts should have been directed, namely, National Health Insurance.

"If our efforts and energies can be redirected along these lines at this time, I believe you and I, as organized physicians, should attack to the greatest extent possible the current concepts of National Health Insurance. We are already late — very late — we must hurry to meet this issue.

"By far the easiest way to lose an argument is to concede your antagonist's basic premise. Organized medicine has done little to this date to dissuade Congress and the American people from the premise that National Health Insurance in one form or another is needed, is proper, and is acceptable. Indeed, as organized medicine, we have even conceded the premise of our antagonists that such is, in fact, proper. We are well along the path to losing the National Health Insurance premise if, for example, we admit the need for governmentally financed catastrophic coverage. I am not denying the need for such coverage, only the need for government financing of this coverage. Is it conceivable to you that any governmentally directed program along these lines would be superior to such offerings as the private insurance industry can make?

"If, as we attack the problems of PSRO and NHI, our philosophic persuasions are not accepted by the Legislators, then we must continue to strive for modification and amendments to preserve the best possible options and maneuverability for our patients and ourselves.

"In conclusion, it is my belief that our efforts will be best served by placing confidence in our PSRO Ad-Hoc Committee and allowing them to proceed with implementation planning for Nebraska on professional review activities, which should include the potential for PSRO and for such other review activities as can be offered to concerned parties on a fee-for-service basis. At the same time, we can remain a part of organized medicine immediately dedicated to the task of mounting a full scale attack on the concept of the need for National Health Insurance which I perceive to be the death knell of medicine as we know it — the best medicine the world has ever known."

There being no further business, the House was recessed until Saturday morning.

SECOND SESSION

The second session of the House of Delegates was held October 5, 1974. The meeting was called to order by the Vice Speaker, Dr. Chas. Landgraf.

The call for a quorum showed 54 delegates present, and the meeting was declared in session.

The Chair called for approval of the minutes of the First Session, and these were approved as printed.

Reports of the Reference Committees were called for and the following were presented:

Reference Committee #1

Reference Committee #1 considered eight reports and one resolution. The Reference Committee submits the following report and recommendations:

(1) REPORT OF THE BOARD OF DIRECTORS

Recommendation:

Your Reference Committee recommends the approval of the Report of the Board of Directors as

carried in the Handbook as submitted by the Chairman of this committee.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(2) REPORT OF THE DELEGATE TO THE AMA (With exception of Item 21, Reference Committee A).

Recommendations:

Your Reference Committee recommends approval of the Report of the Delegate to the AMA (with exception of Item 21, Reference Committee A) as carried in the Handbook as submitted by the AMA Delegate with the following recommendations:

(a) Your Reference Committee recommends that the Executive Secretary of the NMA send a copy of Report C of the Council on Constitution and By Laws, Reference Committee on Amendments to Constitution and By Laws, to the Ad-Hoc Committee on Membership for their edification.

(b) Item 11, Resolution 80, Reference Committee on Amendments to Constitution and By Laws. The Board of Councilors and your Reference Committee feels that the Constitution and By Laws of the NMA should have a provision for expulsion of members convicted of a felony. It is recommended that this be referred to the Constitution and By Laws Committee for review.

(c) Regarding Item 7, Resolution 24, Reference Committee A, it is pointed out that the NMA does endorse a universal health insurance form and we request the Insurance and Prepayment Medical Care Committee notify all third party carriers that universal forms will be used.

(d) Item 3, Report H of CMS, Reference Committee B. Your Reference Committee requests the Executive Secretary supply the complete report regarding insurance for migrant workers to the Insurance and Prepayment Medical Care Committee.

(e) Item 6, Resolution 42, Reference Committee B. Your Reference Committee wishes to point out the efforts of the AMA to prevent the payment of income taxes on medical student loans as a matter of information.

(f) Item 10, Resolutions 60 and 93, Reference Committee B. Your Reference Committee agrees with a ninety-day response period for regulations published in the Federal Register in order to stop government by regulation rather than legislation.

(g) Item 2, Report D of B of T and Resolution 1, Reference Committee C. Your Reference Committee requests that the available data for periodic recertification of physicians be given to the Medical Education Committee and that they in turn give a report to the Spring Meeting of the House of Delegates.

(h) Item 9, Report F of Judicial Council, Reference Committee C. Your Reference Committee points out that the previous House action in limiting third party rounds and describing the attending physician as the responsible physician was adopted. This was introduced by the Nebraska delegation.

(i) Item 21, Resolution 7, Reference Committee C. Your Reference Committee requests that the Executive Secretary send the full report regarding certification of nurses in expanded roles to the Medical Service and Policy Committee.

(j) Item 14, Resolution 129, Reference Committee F. Your Reference Committee recommends that the report be sent by the Executive Secretary to the Medicolegal Advice Committee.

(k) Item 2, Report E of Council on Medical Service, Reference Committee H. Your Reference Committee requests the Executive Secretary send the full report on coordination of professional and lay organizations to the Health Planning Committee.

Your Reference Committee wishes to commend Dr. Roger D. Mason for his fine and lengthy report and his discussion at the Reference Committee.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(3) REPORT OF THE EDITOR OF THE NEBRASKA MEDICAL JOURNAL

Recommendation:

Your Reference Committee recommends the approval of the Report of the Editor of the NEBRASKA MEDICAL JOURNAL, as carried in the Handbook, and again commends Dr. Cole for his continuing excellence in editing the NEBRASKA MEDICAL JOURNAL.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(4) REPORT OF THE EXECUTIVE SECRETARY

Recommendation:

Your Reference Committee recommends the approval of the Report of the Executive Secretary, as carried in the Handbook.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(5) REPORT OF THE CONSTITUTION AND BY LAWS COMMITTEE

Recommendation:

Your Reference Committee recommends approval of the Report of the Constitution and By Laws Committee, as carried in the Handbook as submitted by the Chairman of this committee.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(6) REPORT OF THE PUBLIC RELATIONS COMMITTEE

Recommendation:

Your Reference Committee recommends approval of the Report of the Public Relations Committee, as carried in the Handbook as submitted by the Chairman of this committee, and in addition would like to congratulate them for their efforts in the mass media and the positive attitude they have taken.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(7) PROGRESS REPORT OF THE NEBRASKA REGIONAL MEDICAL PROGRAM

Recommendation:

Your Reference Committee recommends the approval of the Progress Report of the Nebraska Regional Medical Program, as carried in the Handbook, for informational purposes.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(8) REPORT OF THE MEDICAL SERVICE COMMITTEE

Recommendation:

Your Reference Committee recommends approval of the oral Medical Service Committee Report as given by its Chairman, Dr. Robert Shapiro.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(9) RESOLUTION #7 — PRESIDENTIAL HONORARIUM

Your Reference Committee considered the following resolution introduced by the Omaha Medical Society:

> RESOLVED, that the President of the Nebraska Medical Association be provided some form of honorarium, on a per diem basis, and that final decisions will be the responsibility of the Policy Committee:

Recommendation:

Your Reference Committee recommends the approval of this resolution.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #1 AS A WHOLE. This was approved by the House.

Respectfully submitted,
Dr. T. G. Erickson, Fremont, Chairman
Dr. Robert M. Stryker, Omaha
Dr. John T. McGreer, III, Lincoln

Reference Committee #2

Reference Committee #2 considered six reports, one resolution, fifty-year practitioners, and life memberships. The Reference Committee submits the following report and recommendations:

(1) REPORT OF THE AD-HOC DRUG ABUSE EDUCATION COMMITTEE

There was no pertinent discussion for or against the report.

Recommendation:

Your Reference Committee recommends the approval of the Report of the Ad-Hoc Drug Abuse Education Committee, as carried in the Handbook as submitted by the Chairman of this committee.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded and discussion followed relative to the alcohol abuse program, the main concern being that of prescribing the "antabuse" drug without a thorough examination being given. It was suggested that perhaps this should be studied by the Ad-Hoc Drug Abuse Education Committee. The House approved the recommendation of the Reference Committee to adopt this report as carried in the Handbook.

(2) REPORT OF THE AD-HOC COMMITTEE ON MEMBERSHIP

A discussion of this report centered on the last paragraph having to do with eligibility of students and house officers to participate in the fringe benefit programs developed by the Nebraska Medical Association. All of the discussion was in favor of doing everything possible to encourage students and house officers to participate in the activities of the Nebraska Medical Association, and the feeling was expressed that eligibility to participate in the fringe benefit programs would be one way to encourage such participation.

Recommendation:

Your Reference Committee recommends the approval of the Report of the Ad-Hoc Committee on Membership, as carried in the Handbook as submitted by the Chairman of this committee.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(3) REPORT OF THE EMERGENCY MEDICAL SERVICE COMMITTEE

Discussion first centered on the subject of LB 1051, relating to certification of emergency medical technicians, as discussed in the first paragraph of the Report of the Emergency Medical Service Committee. Although there was some discussion of the subject, no specific recommendation was made other than the committee should be encouraged to continue its work and review on this subject.

Discussion of the second item in the Report of the Emergency Medical Service Committee, having to do with life-support training, centered on three main items:

1. Some of the members felt that it was important that the Emergency Medical Service Committee of the NMA have close liaison and cooperation with the other agencies involved in similar endeavors, such as the American Heart Association's life-Support Program, the American College of Surgeons Trauma Committee, and the Emergency Medical Services Division of the State Department of Health.

2. There was considerable discussion concerning recommendation #2 of the Emergency Medical Service Committee. Several members discussing the report expressed opposition to certification until this is better defined, regarding who is to do the certification and how it is to be done. All of the discussants felt that hospital nursing personnel and physicians should be trained and encouraged to develop proficiency in life-support measures, and that one measure of proficiency in this area was the program of the American Heart Association. It was recommended that the words, "and certified" be stricken from the first and also the second sentence of this recommendation #2 in the committee's report, and that certification in basic and advanced life-support not be recommended until such

time as a formal procedure for certification is formulated.

3. Concerning recommendation #4 of the committee's report, discussion of this item, with input from a member of the Scientific Sessions Committee, indicated that a separate room would be available for CPR training at the Spring Session and that such training would be offered at specified times during the Session, leading to a qualification certificate issued by the American Heart Association.

Recommendation:

Your Reference Committee recommends the approval of the Report of the Emergency Medical Service Committee, as carried in the Handbook as submitted by the Chairman of this committee as amended by the Reference Committee.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(3) REPORT OF THE GERIATRICS COMMITTEE

There was no pertinent discussion concerning this report.

Recommendation:

Your Reference Committee recommends the approval of the Report of the Geriatrics Committee, as carried in the Handbook as submitted by the Chairman of this committee.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded. The Chair recognized Dr. Francis who stated that there was a problem in the field of geriatrics, that of nursing home care and the various degrees of nursing home care, specifically skilled nursing home care and intermediate care. Dr. Francis moved that the Geriatrics Committee study this problem and make recommendations to the House of Delegates at their next session. This motion was approved by the House.

The House then approved the adoption of this section of the Reference Committee's report, as amended.

(4) REPORT OF THE MATERNAL AND CHILD HEALTH COMMITTEE

The Chairman of the Maternal and Child Health Committee was present during the discussion of this report.

Recommendation:

Your Reference Committee recommends the approval of the Report of the Maternal and Child Health Committee, as carried in the Handbook as submitted by the Chairman of this committee.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(5) REPORT OF THE SCIENTIFIC SESSIONS COMMITTEE

Discussion of this report centered on the last paragraph of the report concerning a fee to be paid by the members attending the scientific sessions. One of the discussants felt that expenses of the scientific sessions should be borne by the Nebraska Medical Association, either through a special assessment or through an increase in the dues, if such was necessary, rather than by the individual attendants of the scientific sessions. Discussion was also held concerning the importance of documentation of attendance at postgraduate and scientific sessions with regard to recertification. Some of the discussants felt that one way to encourage attendance at the scientific sessions would be to apply for approval for postgraduate training credit for those persons attending the scientific sessions. If the courses were available for postgraduate training approval, then perhaps a small fee for those persons attending the sessions would be appropriate.

It is the recommendation of the Reference Committee that these two items be considered by the Scientific Sessions Committee at a future meeting.

Recommendation:

Your Reference Committee recommends the approval of the Report of the Scientific Sessions Committee, as carried in the Handbook as submitted by the Chairman of this committee.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(5) FIFTY-YEAR PRACTITIONERS

The following list of physicians eligible for fifty-year awards was submitted to the Reference Committee:

Dr. Felipe P. Sucgang, Alliance
Dr. Vorha M. Haffner, St. Libory
Dr. Juan Y. Racines, Palmer
Dr. Wm. E. Wright, Creighton
Dr. Harold S. Morgan, Lincoln
Dr. Herschel B. Morton, Lincoln
Dr. E. Burkett Reed, Lincoln
Dr. Edward Stevenson, North Platte
Dr. Harley E. Anderson, Omaha
Dr. Michael W. Barry, Omaha
Dr. Harley Hotz, Omaha
Dr. Leon S. McGoogan, Omaha
Dr. Charles M. Murphy, Omaha
Dr. Donald J. O'Brien, Omaha
Dr. Wm. H. Scoins, Omaha
Dr. Frederic M. Watke, Yuma, Arizona
Dr. John P. Gilligan, Nebraska City
Dr. Theodore A. Peterson, Holdrege
Dr. Leslie E. Sauer, Tekamah

Recommendation:

Your Reference Committee recommends approval of this list of physicians for fifty-year awards.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(6) LIFE MEMBERSHIPS

The next item considered was the requests for life membership as follows:

Dr. E. Burkett Reed, Lincoln
Dr. W. Ray Hill, Lincoln

Recommendation:

Your Reference Committee recommends approval of these two requests for life membership.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(7) RESOLUTION #8 — INFORMED CONSENT

The final item considered was Resolution #8

having to do with informed consent. There was discussion concerning the difficulties of obtaining adequate informed consent for any specific case. The resolution reads as follows:

> WHEREAS, medical procedures of any type involving touching the patient's person must be authorized, and
>
> WHEREAS, the issue of liability for performing any medical or surgical procedure without a patient's consent is a separate and distinct issue from negligence or malpractice, and
>
> WHEREAS, the proper use of a suitable **informed consent form** gives a decided advantage to a defendant physician in litigation, and
>
> WHEREAS, multiple and varied consent forms are being used within each hospital and each hospital varies from another within the same locale and each locale differs from another in the State of Nebraska, and
>
> WHEREAS, the underlying assumption used by the courts is that disclosure to patients are a part of medical practice and that a standard for disclosure within the medical profession exists, and
>
> WHEREAS, malpractice insurance companies are primarily responsible for defending a physician against malpractice including the informed consent of the patient; therefore be it
>
> RESOLVED, that the Nebraska Medical Association in conjunction with major malpractice carriers devise a standard informed consent form for varied medical, surgical, radiological and other procedures which will stand the test in court, to be used in all hospitals in the State of Nebraska.

Recommendation:

It is the recommendation of the Reference Committee that this resolution, submitted by the Dodge County Medical Society, be referred to the Medico-legal Advice Committee for its consideration.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #2 AS A WHOLE AS AMENDED. This was approved by the House.

Respectfully submitted,

Dr. James P. Schlichtemier, Omaha, Chairman

Dr. P. B. Olsson, Lexington

Dr. Wendell L. Fairbanks, Auburn

Reference Committee #3

Reference Committee #3 considered three reports and one resolution. The Reference Committee submits the following report and recommendations:

(1) REPORT OF THE RELATIVE VALUE STUDY COMMITTEE; REPORT OF THE POLICY COMMITTEE (ITEM 1)

The Report of the Relative Value Study Committee found in the Handbook in conjunction with the first section of the Report of the Policy Committee found in the Handbook, were the first items considered by Reference Committee #3.

The committee heard considerable testimony regarding the draft of the 1975 Relative Value Study which was made available to the Reference Committee at the beginning of its deliberations and had been seen by only a few members of the Association in attendance at the Reference Committee meeting prior to that time.

Your Reference Committee wishes to thank all those who testified before the committee with particular thanks to those members of the Relative Value Study Committee who were in attendance, namely Drs. Nelson, Wilson and Kratochvil.

Recommendations:

Your Reference Committee recommends that the Relative Value Study Committee be commended for this monumental task and that this report be approved with the following recommendations:

1. Copies of this rough draft be made available immediately, if not sooner, to each Councilor and that each member of the NMA be advised that this document is available for review by appointment with his District Councilor. Each delegate should contact his Councilor immediately so that arrangements can be made for prompt review and comments referable to the same should be forwarded to the RVS Committee before November 1, 1974. Copies of specialty sections of the RVS rough draft should be made available to each specialty's RVS Committee on request.
2. Your Reference Committee recommends that the RVS Committee carry out the charge given it by the House of Delegates at the Fall Session of the NMA, 1973, requiring it "to assign precise unit values to pre-operative care, post-operative care, and surgical assistance reflecting an accurate relation to services rendered whether by consulting surgeon, house staff, or other qualified personnel." Your Reference Committee suggests an allowance of 20% of the relative value be considered for surgical assistance and 20% for post-operative care.
3. The Relative Value Study Committee should compile and react to comments from the membership as soon after November 1, 1974, as possible and prepare a final draft. The RVS Committee should review the relative values assigned and using a tentative conversion factor of ten, determine their relationship to current "usual and customary charges."
4. The final draft of the 1975 Relative Value Study should be reviewed by a joint committee made up of all the members of both the Policy Committee and the Relative Value Study Committee and upon approval of this joint committee, this draft should be forwarded for printing.
5. A copy of the final draft of the 1975 Relative Value Study should be made available to each member of the NMA at a relative value of 2.0 units using a conversion factor of ten.
6. The Relative Value Study Committee should be directed to present to the Fall Session of the NMA annually recommendations for

corrections and updating of the Relative Value Study.

(For information of the House, one of the documents used by the RVS Committee in its deliberations and recommendations, was the AMA's CPT Manual — Current Procedural Terminology).

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded and the Chair recognized Dr. Wilson who moved to amend the report to include the following remarks of the Chairman, Dr. Cornelius, regarding suggestions by the Committee to correct the deficiencies in the 1965 schedule:

"The Reference Committee is suggesting that before we finalize this document, each section be reviewed with respect to what this represents from the present values in the 1965 schedule so that it represents an equitable update of the RVS. In the 1965 study, there were some procedures that were listed at a figure that was too low, and since there has been no updating of this in the interim, this is the first opportunity to correct these deficiencies. So some of these will have a significant change.

"The committee recommendation refers mainly to taking single sections throughout the report for the purpose of comparing the 1965 Study with the new Study and determining if there is an equitable change for each section. If in a certain section, they are up 200%, then perhaps we should look at this section a second time. If another section is at no increase or perhaps a decrease, then we ought to see whether or not some changes are going to be made."

Dr. Wilson's motion to amend the Reference Committee report to include these remarks, was approved by the House.

Following considerable discussion regarding the recommendations of the Reference Committee, this section of their report was approved by the House as amended.

(2) RESOLUTION #1 — RELATIVE VALUE STUDY

Next Reference Committee #3 considered the following resolution from the Scotts Bluff County Medical Society:

RESOLVED, that revision of the Relative Value Study be completed as soon as possible; and be it further

RESOLVED, that a new conversion factor with a minimum amount of seven (7) for governmental agencies be immediately adopted.

Recommendation:

Your Reference Committee recommends that this resolution be accepted for information only since the first "RESOLVED" is in the final stages of completion, and the second "RESOLVED" is already being implemented.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(3) REPORT OF THE HEALTH PLANNING COMMITTEE

Recommendations:

(a) Your Reference Committee next considered the Report of the Health Planning Committee found in the Handbook and wishes to commend this committee for its efforts to date. The Reference Committee suggests that the Councilor be encouraged to contact each county medical society in his district and encourage any physician who has not completed his survey questionnaire to date, to do so promptly.

(b) Your Reference Committee further recommends that the Health Planning Committee attempt to develop strong liaison with the Director of the Nebraska State Health Department in its upcoming health manpower study.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #3 AS A WHOLE AS AMENDED. This was approved by the House.

Respectfully submitted,
Dr. C. J. Cornelius, Sidney, Chairman
Dr. Richard Cottingham, McCook
Dr. Robert Benthack, Wayne
Dr. John Porterfield, Lincoln

Reference Committee #4

Reference Committee #4 first heard a report from Dr. Robert Long concerning PSRO activities and policies as reported at a meeting of the Bureau of Health Insurors in Baltimore, Maryland on October 2, 1974, with the following information being submitted as items of general interest concerning this meeting:

Item I. PSRO organizations will have the greatest of latitude and authority imaginable.

Item II. There will be no national norms; local norms will prevail and are determined by the local PSRO organizations.

Item III. In developing norms and acting on individual cases, social and economic factors may be considered as well as purely medical ones. That is, if a patient has no one to care for his or her needs at home and needs care, Medicare or Medicaid will keep paying hospital benefits.

Item IV. All screening will be on a continuing basis beginning on the first day of hospitalization by nurses and/or other trained personnel including doctors, and each case will be prejudged as to the probable duration of stay based upon P.A.S. computerized systems, or whatever local norms the PSRO may develop. The nurse or whomever the screener may be, will contact the attending physician at the appropriate time regarding disposition of the case. If they disagree on the time, a physician member of the local PSRO acts as the referee. If he and the attending physician disagree, a full PSRO Committee hearing makes the decision.

Item V. A PSRO decision is considered final. Appeal by the patient or his representative is directed to a "fair" hearing or to a legal hearing, and not to an intermediary or to the Social Security Administration.

Item VI. The intermediary makes no decisions of any kind and is simply a fiscal agent. They pay the bill submitted and approved by the PSRO organization.

Item VII. Initial reconsiderations prior to an appeal will also be done by PSRO.

Item VIII. Eventually there will be some sort of "quality control," but it is not yet decided as to whether this will be done by the Bureau of Health Insurors, the Social Security Administration, the HEW, the intermediary, or whom.

Item IX. It is undecided at the present time, but the present coverage of three additional days after official notification of discontinuance of coverage may be reduced to one day.

As mentioned, this information is accepted for general interest.

(2) REPORT OF THE AD-HOC COMMITTEE ON PSRO; DELEGATE TO THE AMA, ANNUAL MEETING (ITEM 21, RESOLUTIONS REGARDING PSRO, REFERENCE COMMITTEE A); RESOLUTIONS #2 AND #5

Your Reference Committee next heard discussion concerning the Report of the Ad-Hoc Committee on PSRO, as contained in the Handbook; in addition, the Report of the Delegates to the AMA, Annual Meeting, as contained in Item 21, Resolutions concerning PSRO, Reference Committee A; as well as Resolution #2, submitted by the Lancaster County Medical Society and Resolution #5, submitted by the Omaha Medical Society, were considered jointly due to their interrelationship. These resolutions read as follows:

Resolution #2

WHEREAS, the Department of HEW has designated specific PSRO areas throughout the United States, and specifically designated Nebraska as a statewide PSRO area, and

WHEREAS, such PSRO organization, if finally constituted, will require funding with considerable amounts of monies to become operational, and

WHEREAS, there are limited options for sources of funds; therefore be it

RESOLVED, that the Nebraska Medical Association oppose any special assessment of the membership for the purpose of providing funds for the operation of any statewide PSRO.

Resolution #5

RESOLVED, that the Report of the Nebraska Medical Association Ad-Hoc Committee be altered as follows:

"Strike the word 'preferably' in the last sentence of the last paragraph. Add an 's' to the word 'supplement' in the next to last line of the last paragraph. Place a comma after the word 'supplements' and add the following: 'the implementation planning to be on a voluntary basis with no federal involvement.' "

It will then read:

"The Committee recommends the House of Delegates: (1) Establish the Nebraska Foundation for Medical Care as previously presented to the House of Delegates in April, 1974. (2) Grant authority to the Ad-Hoc Committee on PSRO to proceed with implementation planning as outlined on the attached supplements; the implementation planning to be on a voluntary basis with no federal involvement utilizing, if necessary, membership assessment."

In addition, it was the feeling of your Reference Committee that Resolution #5 lended itself directly and indirectly to Resolution #2, and so these were considered jointly. It was also pointed out by members of the Omaha Medical Society present at the discussion, that Resolution #5, as submitted, contains in its last line a point of reference to membership assessment.

Following discussion in committee, your Reference Committee wishes to revise Resolution #5, to read as follows:

RESOLVED, that the Report of the Nebraska Medical Association Ad-Hoc Committee be altered as follows:

Change the last paragraph to read as follows:

"The Committee recommends the House of Delegates: (1) Establish the Nebraska Foundation for Medical Care as previously presented to the House of Delegates in April, 1974. (2) Grant authority to the Ad-Hoc Committee on PSRO to proceed with the implementation planning for a Foundation and a PSRO, the implementation planning to be on a voluntary basis with no federal involvement."

Your Reference Committee continued to hear extensive and further discussion concerning the composition, make-up, possible methods of funding, possible time schedules, etc., concerning the Nebraska Foundation for Medical Care. Because of ambiguities in language contained in Item IV, in the Articles of Incorporation, it is recommended, "The membership of this Foundation shall consist of members of the Board of Directors," be deleted. It was also pointed out that since the Board of Councilors includes the President, Past President, and President-Elect, the composition of the Board of Directors would necessarily have to be fifteen instead of twelve as indicated in this Item IV.

Recommendation:

With these corrections and amendments to the Report of the Ad-Hoc Committee on PSRO, your Reference Committee recommends acceptance of the Report of the Ad-Hoc Committee on PSRO; as well as acceptance on Resolution #5, submitted by the Omaha Medical Society, as amended; and Resolution #2, as submitted by the Lancaster County Medical Society.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded. There was discussion regarding the Reference Committee's recommendation to amend Resolution #5, particularly the method of funding. The Chair recognized Dr. Cornelius who moved that the revised Resolution #5, recommended by the Reference Committee be amended as follows:

"The Committee recommends the House of Delegates: (1) Establish the Nebraska Foundation for Medical Care as previously presented to the House of Delegates in April, 1974. (2) Grant authority to the Ad-Hoc Committee on PSRO to proceed with the implementation planning for a Foundation and a PSRO."

This motion was seconded, however there was further discussion on the methods of financing. There was a general concensus of opinion that this not be financed by special assessment of the membership. Dr. Dunlap informed the House that he had received an offer from Blue Cross-Blue Shield

to assist financially. He stated that he was assured that this offer was made with no strings attached and the money could be used for whatever purpose the Association wished in establishing the PSRO. Dr. Wilson also indicated that there was potential funding from the Kellogg Foundation for Private Intiatives in PSRO. Dr. Dunlap assured the House that Federal funds would be used only if and when voluntary funds were exhausted.

The Chair called for a vote on the amendment to the Reference Committee's revised Resolution #5, and this was approved by the House.

The Chair recognized Dr. Retelsdorf who stated that the report of the Reference Committee did not refer to the fact that there was opposition to the formation of a Foundation, and he moved that the report of this Reference Committee be amended to show that there was testimony in Reference Committee hearing in opposition to the formation of the Foundation for PSRO activities. This amendment was approved by the House.

Following discussion relative to the formation of a Foundation, Dr. Retelsdorf moved to further amend the report of the Reference Committee to state that if a Foundation is formed and enters into PSRO activities, that the NMA will make every effort to preserve the representation of members of the Association who elect non-cooperation with the Foundation. This amendment was approved by the House.

The House then approved this section of the report of Reference Committee #4 as amended.

(3) POLICY COMMITTEE (ITEM 3)

Recommendation:

Your Reference Committee next considered Item 3, as contained in the Report of the Policy Committee in the Handbook and wishes to recommend acceptance of this portion of the report as written.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #4 AS A WHOLE AS AMENDED. This was approved by the House.

Respectfully submitted,
Dr. Fred J. Rutt, Hastings, Chairman
Dr. William Doering, Franklin
Dr. John D. Coe, Omaha
Dr. Russell L. Gorthey, Lincoln
Dr. Allan C. Landers, Scottsbluff

Reference Committee #5

Reference Committee #5 considered five reports and three resolutions. The Reference Committee submits the following report and recommendations:

(1) REPORT OF THE HEALTH EDUCATION IN SCHOOLS AND COLLEGES COMMITTEE

There was considerable discussion on the report of this committee. The committee was represented by Dr. Sam Fuenning and Dr. John Latenser. Special emphasis was put upon the development and expansion of the Nebraska Health Museum Project and the overall support of the Nebraska Medical Association was encouraged. Furthermore, a desire for more complete input into the health related functions of the State Department of Education was encouraged by the members of the committee. Special emphasis was put upon greater involvement in the areas of school health, health education in rural areas, and patient education.

Recommendation:

Your Reference Committee recommends the approval of the Report of the Health Education in Schools and Colleges Committee, as carried in the Handbook as submitted by the Chairman of this committee.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(2) REPORT OF THE INSURANCE AND PREPAYMENT MEDICAL CARE COMMITTEE

Dr. A. L. Smith, Chairman of the committee, represented the committee at this hearing and gave a rather concise point of view regarding "background insurance" requirements of Nebraska physicians. He encourages the younger physicians and those older physicians who need extra coverage at a relatively low rate of premium to consider the Nebraska Medical Association plans. He also asked that the $2,500 per month disability income insurance program be approved by the House of Delegates.

Recommendation:

Your Reference Committee recommends the approval of the Report of the Insurance and Prepayment Medical Care Committee, as carried in the Handbook as submitted by the Chairman of this committee.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(3) REPORT OF THE MEDICINE AND RELIGION COMMITTEE

Your Reference Committee recommends the approval of the Report of the Medicine and Religion Committee, as carried in the Handbook as submitted by the Chairman of this committee.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(4) REPORT OF THE POLICY COMMITTEE (ITEMS 2, 4, 5 & 6)

(a) Item 2, of the report was considered and some of the recent problems were discussed. It was felt by the Reference Committee that this advisory role for the Policy Committee was a wise and necessary function.

(b) Item 4. The committee was in concurrence with this item as it is written.

(c) Item 5. Once again, it was felt that the Policy Committee's position for offering advice and counsel to this group was a proper role.

(d) Item 6. The appointment of a special Ad-Hoc Committee on National Health Insurance is deemed advisable and necessary by the members of the Reference Committee.

(e) One additional recommendation is made by the members of the Reference Committee and that is that an orientation in the workings of the Nebraska Medical Association be given to new delegates and alternates for their edification and to enhance their contributions to the Nebraska Medical Association.

(f) Your Reference Committee recommends the approval of the Report of the Policy Committee (Items 2, 4, 5 & 6), as carried in the Handbook as submitted by the Chairman of this committee and as amended by your Reference Committee.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(5) REPORT OF SUB-COMMITTEE ON ATHLETIC INJURIES

Dr. Sam Fuenning represented the committee and gave a brief summary of national legislation as pertains to athletic safety.

Recommendation:

Your Reference Committee recommends the approval of the Report of the Sub-Committee on Athletic Injuries, as carried in the Handbook as submitted by the Chairman of this committee.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(6) RESOLUTION #3 — EDUCATIONAL PROGRAM

Resolution #3 was introduced by the Medicolegal Advice Committee and reads as follows:

WHEREAS, law is not static. Rather, it changes constantly.

WHEREAS, it behooves every member of the medical profession to keep abreast of those changes.

WHEREAS, some of the causes of increased liability are:

1. Loss of charitable immunity.
2. Judicial rulings, such as: (a) Avallon; (b) Klema; (c) Lundburg; (d) Darling rulings.
3. Lack of informed consent (Lack of communication).
4. Patient Bill of Rights.
5. Loss of locality rule.

WHEREAS, the medical profession should be aware of the part doctors play in stimulating legal action against the first physician's treatment of a case by succeeding physicians on the case.

WHEREAS, the number of people treating the patient has greatly increased. So has the liability.

WHEREAS, the physician should be aware of his liability in selecting a consultant, even the amount of professional liability he carries.

WHEREAS, the physician should be aware of his liability in the selection of a hospital for the patient.

WHEREAS, the physician should know how to respond when threatened with malpractice action.

WHEREAS, the physician should be aware of his relationship with his attorney.

WHEREAS, the physician should be aware of the types of cases that are getting doctors in trouble.

BE IT RESOLVED, a program of education be developed that will include the entire medical profession — medical students, nurses, interns, residents, and office assistants.

This resolution was discussed by the members of the Reference Committee noting that the "RESOLVED" portion of the resolution, although encompassing, was probably not entirely reasonable due to its tremendous breadth. As other groups already have similar programs going on, it would seem more reasonable for us within the medical profession to take care of our members, medical students, interns and residents and allow those groups who already have established programs to continue their's unhindered.

A further point of information pertaining to this item was that the St. Paul Insurance Companies has offered to send a representative to any medical society meeting in Nebraska for the purpose of discussing professional liability. The St. Paul Companies has assured us that they are sincere and feel that further education in this area might help us to minimize and reduce the number of claims brought against members in the medical profession.

Recommendation:

Your Reference Committee recommends the approval of Resolution #3, with the elimination of the words, "nurses" and "office assistants" in the "RESOLVED" portion of that resolution.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(7) RESOLUTION #4 — HOSPITAL RECORDS

Resolution #4 was introduced by the Omaha Medical Society and reads as follows:

WHEREAS, hospital records contain much valuable information concerning a patient's health and can be of tremendous value in his future care, and

WHEREAS, hospital records should be as complete as possible to promote extending medical care even after the death of the physician who participates in writing them, and

WHEREAS, at present much information is withheld by the physicians to protect the confidentiality of patient-physician relationship, and

WHEREAS, guide lines are presently being drawn to update and clarify access conditions to view and use these confidential records, by the Nebraska Medical Record Association, and

WHEREAS, physicians contribute a large part of the records that are confidential in character; therefore

BE IT RESOLVED, that the physician should have input into these guide lines, and

BE IT FURTHER RESOLVED, that the Committee on Policy at the Nebraska Medical Association be instructed to investigate the work being done to create these guide lines, and

BE IT FURTHER RESOLVED, that this Committee or an equally appropriate committee appointed by the Speaker be instructed to offer their services and cooperate with the Nebraska Hospital Association and the Nebraska Medical Record Association in the creation of such guide lines.

Dr. J. Whitney Kelley presented this resolution to the Reference Committee pointing out that there

has been a definite loss of confidentiality in many of the records that are being put into our medical record libraries. This is due to the fact that third party carriers have to a great extent gone beyond the scope of their interest in extracting information from charts. It was the feeling of those who submitted this resolution that the Nebraska Medical Association establish an ad-hoc committee to create guidelines for those persons being privy to confidential information and to authorize an investigation into how much beyond the realm of necessity the third party carriers have gone in extracting information from medical records. It was felt by the Reference Committee that the resolution in its present form could be better handled by a statement which we refer to as a "sense of the resolution statement" and that is the one carried above.

Recommendation:

Your Reference Committee recommends the approval of the "sense of the resolution statement," rather than the approval of Resolution #4.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was approved by the House.

(8) RESOLUTION #6 — BLUE SHIELD H.M.P.

The final item considered by the committee was Resolution #6, introduced by the Omaha Medical Society and presented to the Reference Committee by Dr. Charles Bressman. This resolution reads as follows:

> WHEREAS, several members of the Omaha Medical Society have been contacted by Blue Shield regarding their HEALTH MAINTENANCE PROGRAM, and
>
> WHEREAS, the majority of the Omaha Medical Society were not contacted, and
>
> WHEREAS, a long-standing mechanism of communication exists between Insurance Carriers and organized medicine (Insurance and Prepayment Committee, etc.), and
>
> WHEREAS, Blue Shield has always enjoyed a favored status with organized medicine in Nebraska; therefore
>
> BE IT RESOLVED, that the House of Delegates censure Blue Shield for this failure to communicate, and
>
> BE IT FURTHER RESOLVED, that H.M.P. plans be communicated to organized medicine through appropriate channels and the Nebraska Medical Association indicate approval or disapproval of member participation in this plan.

This resolution brought about a considerable amount of active and lively discussion between physicians from Omaha and representatives of the Blue Cross-Blue Shield organization. The resolution in essence concerns the breakdown in communication between the Blues and members of the Omaha Medical Society. Because the resolution contains some areas not germane to the issue discussed, the Reference Committee once again decided to make a "sense of the resolution statement" and ask that a communication be made with the Blue Cross-Blue Shield people suggesting further communication with the Omaha physicians prior to the further implementation of their health maintenance program in the City of Omaha. There is no desire by the members of the Reference Committee to apply any censure to Blue Shield, but there is a request that communication from both sides be improved so as to minimize further conflict.

It is also suggested that the House of Delegates instruct the Insurance and Prepayment Medical Care Committee to observe the development of the metropolitan H.M.P. Project.

Recommendation:

Your Reference Committee recommends the approval of the "sense of the resolution statement" made by Reference Committee #5.

MR. SPEAKER, I MOVE THE ADOPTION OF THIS SECTION OF OUR REPORT. This was seconded. The Chair recognized Dr. Bressman who moved that this be amended with the following:

> RESOLVED, that the NMA communicate to Blue Shield their displeasure at Blue Shield's manner of marketing the Health Maintenance Program without appropriate communication to the NMA membership, and be it
>
> FURTHER RESOLVED, that Blue Shield cease further marketing of this program until the total membership is made aware of the plan, and be it
>
> FURTHER RESOLVED, that the H.P.M. of Blue Shield be submitted to our Insurance and Prepayment Medical Care Committee for study and that the committee present a position paper at the next session of the House of Delegates.

Following considerable discussion, the Chair ruled that each RESOLVED would be considered separately. The first and third RESOLVED were approved by the House, however the second was not approved.

The House then approved this section of the report of Reference Committee #5 as amended.

MR. SPEAKER, I MOVE THE ADOPTION OF THE REPORT OF YOUR REFERENCE COMMITTEE #5 AS A WHOLE AS AMENDED. This was approved by the House.

Respectfully submitted,
Dr. V. F. Colon, Friend,
Chairman
Dr. James Carlson, Verdigre
Dr. Myron E. Samuelson, Wymore

The Chair recognized Dr. McWhorter who asked that the record show that the Omaha Delegation supported the directives as given in the original Resolution #5 submitted and defeated by the House. The Chair ruled that this would be included in the record.

The Chair recognized Dr. Cornelius who read an excerpt from the AMA Newsletter relative to a statement made by HEW Secretary Weinberger regarding increase in costs of medical care. The figures in general indicated that physicians fees have increased at a slower rate on the consumer price index than other items. Yet according to the article, Secretary Weinberger singled out health care providers as special offenders. The Chair ruled that these remarks be sent to the Public Relations Committee for use in a news release to the public.

There being no further business, the House of Delegates was adjourned.

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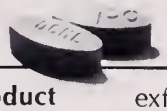

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Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species).

Note: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in chronic and recurrent urinary tract infections.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia in elderly patients on diuretics, primarily thiazides. Sore throat, fever, pallor or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. Data are insufficient to recommend use in infants and children under 12.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, allergy or bronchial asthma; and in those with glucose-6-phosphate dehydrogenase deficiency, where hemolysis may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12.

Usual adult dosage: Two tablets b.i.d. for 10 to 14 days. For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

Supplied: Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10.

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